of the enactment of this Act [Oct. 6, 2014], the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of specifying quality measures and resource use and other measures under subsections (c) and (d) of section 1899B of the Social Security Act, as added by subsection (a), and, as the Secretary determines appropriate, other similar provisions of, including payment adjustments under, title XVIII of such Act (42 U.S.C. 1395 et seq.).''

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396. Medicaid and CHIP Payment and Access Commission

(a) Establishment

There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ''MACPAC'').

(b) Duties

(1) Review of access policies for all States and annual reports

MACPAC shall—

(A) review policies of the Medicaid program established under this subchapter (in this section referred to as ''Medicaid'') and the State Children's Health Insurance Program established under subchapter XXI (in this section referred to as ''CHIP'') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) Specific topics to be reviewed

Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies

Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) Eligibility policies

Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) Enrollment and retention processes

Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) Coverage policies

Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) Quality of care

Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) Interaction of Medicaid and CHIP payment policies with health care delivery generally

The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this subchapter or subchapter XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) Interactions with Medicare and Medicaid

Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under subchapter XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) Other access policies

The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) Recommendations and reports of State-specific data

MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) Creation of early-warning system

MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) Comments on certain secretarial reports and regulations

(A) Certain secretarial reports

If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) Regulations

MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) Agenda and additional reviews

(A) In general

MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this subchapter or subchapter XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) Review and reports regarding Medicaid DSH

(i) In general

MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1396r–4 of this title. Each report shall include the information specified in clause (ii).

(ii) Required report information

Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) Data

Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1396r–4(j) of this title, cost reports submitted under subchapter XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) Submission deadlines

The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) Availability of reports

MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) Appropriate committee of Congress

For purposes of this section, the term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) Voting and reporting requirements

With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) Examination of budget consequences

Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and

State-specific budget consequences of the recommendations.

(11) Consultation and coordination with MEDPAC

(A) In general

MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ''MedPAC'') established under section 1395b–6 of this title in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under subchapter XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) Information sharing

MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) Consultation with States

MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) Coordinate and consult with the Federal Coordinated Health Care Office

MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081[1] of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(14) Programmatic oversight vested in the Secretary

MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) Membership

(1) Number and appointment

MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) Qualifications

(A) In general

The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) Inclusion

The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) Majority nonproviders

Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) Ethical disclosure

The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying subchapter I of chapter 131 of title 5.

(3) Terms

(A) In general

The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) Vacancies

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) Compensation

While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5; and while so serving away from home and the member's regular place of business, a member may be allowed travel ex-

[1] See References in Text note below.

penses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) Chairman; Vice Chairman

The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member[2] as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) Meetings

MACPAC shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants

Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5 governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 6101 of title 41);

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) Powers

(1) Obtaining official data

MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1396b(a) and 1397ee(a) of this title, from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) Data collection

In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) Access of GAO to information

The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) Periodic audit

MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) Funding

(1) Request for appropriations

MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) Authorization

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) Funding for fiscal year 2010

(A) In general

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) Transfer of funds

Notwithstanding section 1397dd(a)(13) of this title, from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) Availability

Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

(Aug. 14, 1935, ch. 531, title XIX, §1900, as added Pub. L. 111–3, title V, §506(a), Feb. 4, 2009, 123 Stat. 91; amended Pub. L. 111–148, title II, §2801(a), Mar. 23, 2010, 124 Stat. 328; Pub. L. 113–93, title II, §221(b), Apr. 1, 2014, 128 Stat. 1076; Pub. L. 117–286, §4(c)(43), Dec. 27, 2022, 136 Stat. 4359.)

[2] So in original. Probably should be followed by a comma.

Editorial Notes

REFERENCES IN TEXT

Section 2081 of the Patient Protection and Affordable Care Act, referred to in subsec. (b)(13), probably means section 2602 of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 315, which is classified to section 1315b of this title. Section 2602 of Pub. L. 111–148 established the Federal Coordinated Health Care Office, and Pub. L. 111–148 does not contain a section 2081.

CODIFICATION

In subsec. (d)(3), ''section 6101 of title 41'' substituted for ''section 3709 of the Revised Statutes (41 U.S.C. 5)'' on authority of Pub. L. 111–350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1396, act Aug. 14, 1935, ch. 531, title XIX, § 1901, as added Pub. L. 89–97, title I, § 121(a), July 30, 1965, 79 Stat. 343; amended Pub. L. 93–233, § 13(a)(1), Dec. 31, 1973, 87 Stat. 960; Pub. L. 98–369, div. B, title VI, § 2663(j)(3)(C), July 18, 1984, 98 Stat. 1171, which related to appropriations, was transferred to section 1396–1 of this title.

AMENDMENTS

2022—Subsec. (c)(2)(D). Pub. L. 117–286 substituted ''subchapter I of chapter 131 of title 5.'' for ''title I of the Ethics in Government Act of 1978 (Public Law 95–521).''

2014—Subsec. (b)(6). Pub. L. 113–93 designated existing provisions as subpar. (A), inserted heading, and added subpar. (B).

2010—Subsec. (b)(1). Pub. L. 111–148, § 2801(a)(1)(A)(i), inserted ''for all States'' before ''and annual'' in heading.

Subsec. (b)(1)(A). Pub. L. 111–148, § 2801(a)(1)(A)(ii), struck out ''children's'' before ''access''.

Subsec. (b)(1)(B). Pub. L. 111–148, § 2801(a)(1)(A)(iii), inserted '', the Secretary, and States'' after ''Congress''.

Subsec. (b)(1)(C). Pub. L. 111–148, § 2801(a)(1)(A)(iv), substituted ''March 15'' for ''March 1''.

Subsec. (b)(1)(D). Pub. L. 111–148, § 2801(a)(1)(A)(v), substituted ''June 15'' for ''June 1''.

Subsec. (b)(2)(A)(i). Pub. L. 111–148, § 2801(a)(1)(B)(i)(I), inserted ''the efficient provision of'' after ''expenditures for'' and substituted ''payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services'' for ''hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees''.

Subsec. (b)(2)(A)(iii). Pub. L. 111–148, § 2801(a)(1)(B)(i)(II), inserted ''(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)'' after ''CHIP beneficiaries''.

Subsec. (b)(2)(B) to (H). Pub. L. 111–148, § 2801(a)(1)(B)(ii)–(v), added subpars. (B) to (E) and (G), redesignated former subpars. (B) and (C) as (F) and (H), respectively, and, in subpar. (H), inserted ''and preventive, acute, and long-term services and supports'' after ''barriers''.

Subsec. (b)(3). Pub. L. 111–148, § 2801(a)(1)(D), added par. (3). Former par. (3) redesignated (4).

Subsec. (b)(4). Pub. L. 111–148, § 2801(a)(1)(C), (E), redesignated par. (3) as (4) and substituted '', as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.'' for ''or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.'' Former par. (4) redesignated (5).

Subsec. (b)(5). Pub. L. 111–148, § 2801(a)(1)(C), (F), redesignated par. (4) as (5), inserted ''and regulations'' after ''reports'' in heading, designated existing provisions as subpar. (A) and inserted heading, inserted ''and the Secretary'' after ''appropriate committees of Congress'' in subpar. (A), and added subpar. (B). Former par. (5) redesignated (6).

Subsec. (b)(6) to (10). Pub. L. 111–148, § 2801(a)(1)(C), (G), redesignated pars. (5) to (9) as (6) to (10), respectively, and inserted '', and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations'' in par. (10) before period at end.

Subsec. (b)(11) to (14). Pub. L. 111–148, § 2801(a)(1)(H), added pars. (11) to (14).

Subsec. (c)(2)(A), (B). Pub. L. 111–148, § 2801(a)(2)(A), added subpars. (A) and (B) and struck out former subpars. (A) and (B) which related to MACPAC membership qualifications.

Subsec. (d)(2). Pub. L. 111–148, § 2801(a)(3), inserted ''and State'' after ''Federal''.

Subsec. (e)(1). Pub. L. 111–148, § 2801(a)(4), inserted ''and, as a condition for receiving payments under sections 1396b(a) and 1397ee(a) of this title, from any State agency responsible for administering Medicaid or CHIP,'' after ''United States''.

Subsec. (f). Pub. L. 111–148, § 2801(a)(5), substituted ''Funding'' for ''Authorization of appropriations'' in heading, inserted ''(other than for fiscal year 2010)'' before ''in the same manner'' in par. (1), and added pars. (3) and (4).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 111–3, § 3, Feb. 4, 2009, 123 Stat. 10, provided that:

''(a) GENERAL EFFECTIVE DATE.—Unless otherwise provided in this Act [enacting this section and sections 247d–9, 1320b–9a, 1396e–1, 1396w–2, and 1397kk to 1397mm of this title and section 657p of Title 15, Commerce and Trade, transferring former section 1396 of this title to section 1396–1 of this title, amending sections 300gg, 1308, 1320b–9, 1320b–9a, 1396a, 1396b, 1396r–1, 1396r–4, 1396u–7, 1397bb to 1397ee, and 1397gg to 1397jj of this title, section 1514 of Title 19, Customs Duties, sections 5701 to 5703, 5712, 5713, 5721 to 5723, 5741, 6103, and 9801 of Title 26, Internal Revenue Code, and sections 1022, 1132, and 1181 of Title 29, Labor, enacting provisions set out as notes under this section and sections 1305, 1396a, 1396b, 1396d, 1396u–7, 1396u–8, 1396w–2, 1397bb to 1397ee, 1397gg, and 1397hh of this title, section 1514 of Title 19, sections 5701 to 5703, 5711, 5712, 6103, and 6655 of Title 26, and section 1181 of Title 29, amending provisions set out as a note under section 1397gg of this title, and repealing provisions set out as notes under sections 1397aa and 1397ee of this title], subject to subsections (b) through (d), this Act (and the amendments made by this Act) shall take effect on April 1, 2009, and shall apply to child health assistance and medical assistance provided on or after that date.

''(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX [42 U.S.C. 1396 et seq.] or State child health plan under [title] XXI [42 U.S.C. 1397aa et seq.] of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an 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 [Feb. 4, 2009]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

''(c) COORDINATION OF CHIP FUNDING FOR FISCAL YEAR 2009.—Notwithstanding any other provision of law, insofar as funds have been appropriated under section 2104(a)(11), 2104(k), or 2104(*l*) of the Social Security Act [42 U.S.C. 1397dd(a)(11), (k), (*l*)], as amended by section 201 of Public Law 110–173, to provide allotments to States under CHIP for fiscal year 2009—

''(1) any amounts that are so appropriated that are not so allotted and obligated before April 1, 2009 are rescinded; and

''(2) any amount provided for CHIP allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

''(d) RELIANCE ON LAW.—With respect to amendments made by this Act (other than title VII) [enacting this section and sections 1320b–9a, 1396e–1, 1396w–2, and 1397kk to 1397mm of this title, amending sections 300gg, 1308, 1320b–9, 1320b–9a, 1396a, 1396b, 1396r–1, 1396r–4, 1396u–7, 1397bb to 1397ee, and 1397gg to 1397jj of this title, section 9801 of Title 26, Internal Revenue Code, and sections 1022, 1132, and 1181 of Title 29, Labor, amending provisions set out as a note under section 1397gg of this title, and repealing provisions set out as notes under sections 1397aa and 1397ee of this title] that become effective as of a date—

''(1) such amendments are effective as of such date whether or not regulations implementing such amendments have been issued; and

''(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.] on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance.''

THINK DIFFERENTLY DATABASE

Pub. L. 118–225, Jan. 4, 2025, 138 Stat. 2817, provided that:

''SECTION 1. SHORT TITLE.

''This Act may be cited as the 'Think Differently Database Act'.

''SEC. 2. PROMOTING AWARENESS OF AVAILABLE RESOURCES FOR INDIVIDUALS WITH DISABILITIES.

''(a) IN GENERAL.—Not later than 3 years after the date of the enactment of this Act [Jan. 4, 2025], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish and update periodically a publicly available website to provide information with respect to resources and information for people with a disability and the caregivers and families of such people. Such website shall include—

''(1) information on eligibility to receive medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) based on a disability, including general information about eligibility under subclauses (XIII), (XV), (XVI), and (XIX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii));

''(2) which States offer eligibility under subclauses (XIII), (XV), (XVI), and (XIX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii));

''(3) each State's specific eligibility requirements, if applicable, under subclauses (XIII), (XV), (XVI), and (XIX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii));

''(4) information about how to contact each State's Medicaid office for information about Medicaid, including links and phone numbers for State contacts;

''(5) general information on Medicaid-covered long-term services and supports that may be available to individuals eligible for medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan); and

''(6) where applicable, the average amount of time that individuals newly enrolled in a State's waiver program for home and community-based services in the past 12 months were on the list of individuals waiting to enroll in such waiver program, in such a manner and process as described in section 441.311(d)(1)(iii) of title 42, Code of Federal Regulations.

''(b) PROMOTION.—The Secretary shall, as applicable and appropriate, identify and disseminate promotional activities to improve, among people with a disability and the caretakers and families of such people, the awareness of the resources included in the website established under subsection (a), such as through collaboration with the Social Security Administration during its annual updates to the Red Book.

''(c) MODEL.—In establishing the website under this section, the Secretary may use the website thinkdifferently.net as a model.

''(d) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995'), shall not apply to the implementation of this section.''

PURPOSE

Pub. L. 111–3, §2, Feb. 4, 2009, 123 Stat. 10, provided that: ''It is the purpose of this Act [see Effective Date note above] to provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act [42 U.S.C. 1397aa et seq., 1396 et seq.] in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles.''

MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS

Pub. L. 111–3, title II, §213, Feb. 4, 2009, 123 Stat. 56, provided that:

''(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of children who, because of migration of families, emergency evacuations, natural or other disasters, public health emergencies, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

''(b) REPORT TO CONGRESS.—After development of such model process, the Secretary of Health and Human Services shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).''

IMPROVED ACCESSIBILITY OF DENTAL PROVIDER INFORMATION TO ENROLLEES UNDER MEDICAID AND CHIP

Pub. L. 111–3, title V, §501(f), Feb. 4, 2009, 123 Stat. 88, provided that: ''The Secretary [of Health and Human Services] shall—

''(1) work with States, pediatric dentists, and other dental providers (including providers that are, or are affiliated with, a school of dentistry) to include, not later than 6 months after the date of the enactment of this Act [Feb. 4, 2009], on the Insure Kids Now website (http://www.insurekidsnow.gov/) and hotline (1–877–KIDS–NOW) (or on any successor websites or hotlines) a current and accurate list of all such dentists and providers within each State that provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly; and

''(2) work with States to include, not later than 6 months after the date of the enactment of this Act, a description of the dental services provided under each State plan (or waiver) under Medicaid and each State child health plan (or waiver) under CHIP on such Insure Kids Now website, and shall ensure that such list is updated at least annually.''

DEADLINE FOR INITIAL APPOINTMENTS

Pub. L. 111–3, title V, § 506(b), Feb. 4, 2009, 123 Stat. 95, provided that: ''Not later than January 1, 2010, the Comptroller General of the United States shall appoint the initial members of the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act [42 U.S.C. 1396] (as added by subsection (a)).''

ANNUAL REPORT

Pub. L. 111–3, title V, § 506(c), Feb. 4, 2009, 123 Stat. 95, provided that: ''Not later than January 1, 2010, and annually thereafter, the Secretary [of Health and Human Services], in consultation with the Secretary of the Treasury, the Secretary of Labor, and the States (as defined for purposes of Medicaid), shall submit an annual report to Congress on the financial status of, enrollment in, and spending trends for, Medicaid for the fiscal year ending on September 30 of the preceding year.''

NO FEDERAL FUNDING FOR ILLEGAL ALIENS; DISALLOWANCE FOR UNAUTHORIZED EXPENDITURES

Pub. L. 111–3, title VI, § 605, Feb. 4, 2009, 123 Stat. 100, as amended by Pub. L. 111–148, title II, § 2102(a)(2), Mar. 23, 2010, 124 Stat. 288, provided that: ''Nothing in this Act [see Effective Date note above] allows Federal payment for individuals who are not lawfully residing in the United States. Titles XI, XIX, and XXI of the Social Security Act [42 U.S.C. 1301 et seq., 1396 et seq., 1397aa et seq.] provide for the disallowance of Federal financial participation for erroneous expenditures under Medicaid and under CHIP, respectively.''

DEFINITIONS

Pub. L. 111–3, § 1(c), Feb. 4, 2009, 123 Stat. 8, provided that: ''In this Act [see Effective Date note above]:

''(1) CHIP.—The term 'CHIP' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

''(2) MEDICAID.—The term 'Medicaid' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.''

§ 1396–1. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, ch. 531, title XIX, § 1901, as added Pub. L. 89–97, title I, § 121(a), July 30, 1965, 79 Stat. 343; amended Pub. L. 93–233, § 13(a)(1), Dec. 31, 1973, 87 Stat. 960; Pub. L. 98–369, div. B, title VI, § 2663(j)(3)(C), July 18, 1984, 98 Stat. 1171.)

Editorial Notes

CODIFICATION

Section was formerly classified to section 1396 of this title.

AMENDMENTS

1984—Pub. L. 98–369 struck out ''of Health, Education, and Welfare'' after ''Secretary''.

1973—Pub. L. 93–233 substituted ''disabled individuals'' for ''permanently and totally disabled individuals''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by 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.

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the estab-

lishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan, and, subject to section 1396b(i) of this title, including a specification that the single State agency described in paragraph (5) will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the methods that such agency will use to ensure such transportation) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under chapter 21 of title 41 to persons described in section 2102(a)(3) of title 41;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV if the State is not eligible to participate in the State plan program established under subchapter XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide—

(A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

(i) the administration of the plan; and

(ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 [42 U.S.C. 1771 et seq.] and free or reduced price lunches under the Richard B. Russell National School Lunch Act [42 U.S.C. 1751 et seq.], in accordance with section 9(b) of that Act [42 U.S.C. 1758(b)], using data standards and formats established by the State agency; and

(B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act under which the State shall establish procedures to ensure that—

(i) a child receiving medical assistance under the State plan under this subchapter whose family income does not exceed 133 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act and free breakfasts under the Child Nutrition Act of 1966 without further application; and

(ii) the State agencies responsible for administering the State plan under this subchapter, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act [42 U.S.C. 1758(b)];

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section

1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions,

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title, and

(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (13)(B), (17), (21), (28), (29), and (30) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A or part E of subchapter IV (including individuals eligible under this subchapter by reason of section 602(a)(37),[1] 606(h),[1] or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)[1] of this title),

(II)(aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase ''the first day of the month following'',

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (*l*)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (*l*)(2)(A) for such a family;[2]

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (*l*)(1) and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(B) for such a family,

(VII) who are described in subparagraph (D) of subsection (*l*)(1) and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(C) for such a family;[2]

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsection (k);[2] or

(IX) who—

(aa) are under 26 years of age;

(bb) are not described in and are not enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

(cc) were in foster care under the responsibility of a State on the date of attaining 18 years of age or such higher age as the State has elected under section 675(8)(B)(iii) of this title; and

(dd) were enrolled in a State plan under this subchapter or under a waiver of such a plan while in such foster care;[3]

(ii) at the option of the State, to[4] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to[4] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate

[1] See References in Text note below.

[2] So in original. The semicolon probably should be a comma.

[3] So in original. Probably should be followed by ''and''.

[4] So in original. The word ''to'' probably should not appear.

State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) 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, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI, or a State supplementary payment; [2]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(*o*) of this title; [2]

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV; [2]

(IX) who are described in subsection (*l*)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); [2]

(X) who are described in subsection (m)(1); [2]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title; [2]

(XII) who are described in subsection (z)(1) (relating to certain TB-infected individuals); [2]

(XIII) who are in families whose income is less than 250 percent of the income 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, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396*o* of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine); [2]

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title; [2]

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish; [2]

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title

and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);[2]

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State;[2]

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);[2]

(XIX) who are disabled children described in subsection (cc)(1);[2]

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);[2]

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);[2]

(XXII) 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;[2] or

(XXIII) during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, who are uninsured individuals (as defined in subsection (ss));

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

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

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

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5), (13)(B), and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

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

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title (including such individuals enrolled under section 1395*o*(b) of this title) but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the offi-

cial poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1396u–3 and 1396d(p)(4) of this title, for making medical assistance available for medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title (including such individuals enrolled under section 1395*o*(b) of this title) but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in subsection (u)(1); and

(G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396*o*(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(*o*) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (*l*)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services), medical assistance for services related to other conditions which may complicate pregnancy, and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (VIII), medical assistance for services related to other conditions which may complicate pregnancy, and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) and section 1396*o*(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made

available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r–4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)) and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer[5] (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1) and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (XVII) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII), and (XVIII) the medical assistance made available to an uninsured individual (as defined in subsection (ss)) who is eligible for medical assistance only because of subparagraph (A)(ii)(XXIII) shall be limited to medical assistance for any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product), any service described in section 1396*o*(a)(2)(G) of this title that is furnished during any such portion, any vaccine described in section 1396d(a)(4)(E) of this title (and the administration of such vaccine) that is furnished during any such portion, and testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), and (XIX) medical assistance shall be made available during the period described in section 1396d(a)(4)(E) of this title for vaccines described in such section and the administration of such vaccines, for any individual who is eligible for and receiving medical assistance under the State plan or under a waiver of such plan (other than an individual who is eligible for medical assistance consisting only of payment of premiums pursuant to subparagraph (E) or (F) or section 1396u–3 of this title), notwithstanding any provision of this subchapter or waiver under section 1315 of this title impacting such individual's eligibility for medical assistance under such plan or waiver to coverage for a limited type of benefits and services that would not otherwise include coverage of a COVID–19 vaccine and its administration;

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section[5] (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with re-

[5] So in original. Probably should be followed by a comma.

spect to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 [42 U.S.C. 1786];

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1396r–4 of this title) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII and for payment of amounts under section 1396d(*o*)(3) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

(C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of subchapter XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1395w–4(d) of this title for the year involved were the conversion factor under such section for 2009);

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396*o* of this title;

(15) provide for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan in accordance with subsection (bb);

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (e)(14), (e)(15), (*l*)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are 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, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in

the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,,[6] transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii)[1] or section 1383(a)(4)(A)(i) and (ii)[1] of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g), in section 1396n of this title, and in section 1396u–2(a) of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed

[6] So in original.

to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396*o* of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396*o* of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396*o* of this title) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.;[6] and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws

under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title) for, or are provided, medical assistance under a State plan (or under a waiver of the plan) under this subchapter and child health assistance under subchapter XXI, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii)(I) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan (or under a waiver of such plan); and

(II) in the case of a responsible third party (other than the original medicare fee-for-service program under parts A and B of subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of such subchapter, a reasonable cost reimbursement plan under section 1395mm of this title, a health care prepayment plan under section 1395*l* of this title, or a prescription drug plan offered by a PDP sponsor under part D of such subchapter) that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under this subchapter, accept authorization provided by the State that the item or service is covered under the State plan (or waiver of such plan) for such individual, as if such authorization were the prior authorization made by the third party for such item or service;

(iii) not later than 60 days after receiving any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service, respond to such inquiry; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point-of-sale that is the basis of the claim, or in the case of a responsible third party (other than the original medicare fee-for-service program under parts A and B of subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of such subchapter, a reasonable cost reimbursement plan under section 1395mm of this title, a health care prepayment plan under section 1395*l* of this title, or a prescription drug plan offered by a PDP sponsor under part D of such subchapter) a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

(B) for including in ''nursing facility services'' at least the items and services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically re-

places the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a–3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a–3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1320a–7(b)(9) of this title;

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a–7 of this title or section 1320a–7a of this title, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a–7(c)(3)(B) and 1320a–7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII, any other State plan under this subchapter (or waiver of the plan), or any State child health plan under subchapter XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such

section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide, in accordance with subsection (kk)(8) (as applicable), that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that—

(A) the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan; and

(B) not later than December 31, 2010, the State shall—

(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1395ddd(h) of this title, subject to such exceptions or requirements as the Secretary may require for purposes of this subchapter or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

(ii) provide assurances satisfactory to the Secretary that—

(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

(II) from such amounts recovered, payment—

(aa) shall be made on a contingent basis for collecting overpayments; and

(bb) may be made in such amounts as the State may specify for identifying underpayments;

(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

(aa) for purposes of section 1396b(a)(7) of this title, that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

(bb) that section 1396b(d) of this title shall apply to amounts recovered under the program; and

(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations,[7] the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 1397hh(e)[8] of this title and

(iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the

[7] So in original. Probably should be ''Investigation,''.

[8] Probably means the subsec. (e) of section 1397hh relating to information on dental care for children.

supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

(46)(A) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title; and

(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this subchapter, that the State shall satisfy the requirements of—

(i) section 1396b(x) of this title; or

(ii) subsection (ee);

(47) provide—

(A) at the option of the State, for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1396r–1 of this title and provide for making medical assistance for items and services described in subsection (a) of section 1396r–1a of this title available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period in accordance with such section; and

(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1396r–1, 1396r–1a, 1396r–1b, or 1396r–1c of this title (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1396r–2 of this title;

(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51) meet the requirements of section 1396r–5 of this title (relating to protection of community spouses);

(52) meet the requirements of section 1396r–6 of this title (relating to extension of eligibility for medical assistance);

(53) provide—

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966 [42 U.S.C. 1786]), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1396r–8(k) of this title), comply with the applicable requirements of section 1396r–8 of this title;

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XXIII)—

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV and which include facilities defined as disproportionate share hospitals under section 1396r–4(a)(1)(A) of this title and Federally-qualified health centers described in section 1396d(1)(2)(B)[9] of this title, and

(B) using applications which are other than those used for applications for aid under such part;

[9] So in original. Probably should be section ''1396d(*l*)(2)(B)''.

(56) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title) receiving funds under the plan shall comply with the requirements of subsection (w);

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w);

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (x)) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1396g–1 of this title;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1396s of this title;

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of section 1396u–1 of this title;

(64) provide, not later than 1 year after August 5, 1997, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this subchapter;

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1395x(n) of this title, and the State shall not issue or renew such a supplier number for any such supplier unless—

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1320a–3(a)(2) of this title) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary under section 1395m(a)(16)(B) of this title and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section;

(66) provide for making eligibility determinations under section 1396u–5(a) of this title;

(67) provide, with respect to services covered under the State plan (but not under subchapter XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary);

(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1396u–6 of this title;

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

(B) may be conducted under contract with a broker who—

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1395nn of this title and such other prohibitions and requirements as the Secretary determines to be appropriate);

(71) provide that the State will implement an asset verification program as required under section 1396w of this title;

(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services;

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this subchapter that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this subchapter;

(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg);

(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan;

(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act [42 U.S.C. 300kk];

(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (kk);

(78) provide that, not later than January 1, 2017, in the case of a State that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);

(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;

(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;

(81) provide for implementation of the payment models specified by the Secretary under section 1315a(c) of this title for implementation on a nationwide basis unless the State

demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State;

(82) provide that the State agency responsible for administering the State plan under this subchapter provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1320a–7n(b)(2) of this title;

(83) provide that, not later than January 1, 2017, in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1396n(b)(1) of this title (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public website of the State agency administering the State plan, a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—

(A) includes—

(i) with respect to each such physician or provider—

(I) the name of the physician or provider;

(II) the specialty of the physician or provider;

(III) the address at which the physician or provider provides services; and

(IV) the telephone number of the physician or provider; and

(ii) with respect to any such physician or provider participating in such a primary care case-management system, information regarding—

(I) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this subchapter; and

(II) the physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician's or provider's office; and

(B) may include, at State option, with respect to each such physician or provider—

(i) the Internet website of such physician or provider; or

(ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this subchapter;

(84) provide that—

(A) the State shall not terminate eligibility for medical assistance under the State plan (or waiver of such plan) for an individual who is an eligible juvenile (as defined in subsection (nn)(2)) because the juvenile is an inmate of a public institution (as defined in subsection (nn)(3)), but, subject to subparagraph (D), may suspend coverage during the period the juvenile is such an inmate (or in the case of a State electing the option described in the subdivision (A) following paragraph (31) of section 1396d(a) of this title, during such period beginning after the disposition of charges with respect to such individual);

(B) in the case of an individual who is an eligible juvenile described in paragraph (2)(A) of subsection (nn), the State shall, prior to the individual's release from such a public institution, conduct a redetermination of eligibility for such individual with respect to such medical assistance (without requiring a new application from the individual) and, if the State determines pursuant to such redetermination that the individual continues to meet the eligibility requirements for such medical assistance, the State shall restore coverage for such medical assistance to such an individual upon the individual's release from such public institution;

(C) in the case of an individual who is an eligible juvenile described in paragraph (2)(B) of subsection (nn), the State shall process any application for medical assistance submitted by, or on behalf of, such individual such that the State makes a determination of eligibility for such individual with respect to such medical assistance upon release of such individual from such public institution; and

(D) in the case of an individual who is an eligible juvenile described in subsection (nn)(2) and is within 30 days of the date on which such eligible juvenile is scheduled to be released from a public institution following adjudication, the State shall have in place a plan, and in accordance with such plan, provide for—

(i) in the 30 days prior to the release of such eligible juvenile from such public institution (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with such institution, any screening or diagnostic service which meets reasonable standards of medical and dental practice, as determined by the State, or as indicated as medically necessary, in accordance with paragraphs (1)(A) and (5) of section 1396d(r) of this title, including a behavioral health screening or diagnostic service; and

(ii) in the 30 days prior to the release of such eligible juvenile from such public institution, and for at least 30 days following the release of such eligible juvenile from such institution, targeted case management services, including referrals for such eligible juvenile to the appropriate care and services available in the geographic region of the home or residence of such eligible juvenile (where feasible) under the State plan (or waiver of such plan);

(85) provide that the State is in compliance with the drug review and utilization requirements under subsection (*oo*)(1);

(86) provide, at the option of the State, for making medical assistance available on an inpatient or outpatient basis at a residential pediatric recovery center (as defined in subsection (pp)) to infants with neonatal abstinence syndrome; and

(87) provide for a mechanism, which may include attestation, that ensures that, with respect to any provider (including a transportation network company) or individual driver of nonemergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), at a minimum—

(A) each such provider and individual driver is not excluded from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

(B) each such individual driver has a valid driver's license;

(C) each such provider has in place a process to address any violation of a State drug law; and

(D) each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X (or subchapter XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I (or subchapter XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X (or subchapter XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV and who for such month was entitled to monthly insurance benefits under subchapter II shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II resulting from enactment of Public Law 92–336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title.

(b) Approval by Secretary

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

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

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Lower payment levels or applying for benefits as condition of applying for, or receiving, medical assistance

Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if the State requires individuals described in subsection (*l*)(1) to apply for assistance under the State program funded under part A of subchapter IV as a condition of applying for or receiving medical assistance under this subchapter.

(d) Performance of medical or utilization review functions

If a State contracts with an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, or a utilization and quality control peer review organization[10] having a contract with the Secretary under part B of subchapter XI for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI and provides for such assurances

[10] So in original. Probably should be ''a quality improvement organization''.

of satisfactory performance by such an entity or organization as the Secretary may prescribe.

(e) Continuation and extension of eligibility of certain individuals; Express Lane option for children

(1) Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV and have earned income, see section 1396r–6 of this title.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), with a primary care case manager (as defined in section 1396d(t) of this title), or with an eligible organization with a contract under section 1395mm of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

(B) For purposes of subparagraph (A), the term ''minimum enrollment period'' means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1382c(a) of this title;

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter,

shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter XVI.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires). Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1396b(v) of this title, the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) and subsection (*l*)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r–1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (*l*)(1) or paragraph (2) of section 1396d(n) of this title—

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of

the month in which the determination first occurs. For purposes of payment to a State under section 1396b(a) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV pursuant to section 602(a)(43)[1] of this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV and such aid is terminated pursuant to section 602(a)(43)[1] of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1396e of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term ''minimum enrollment period'' means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

(12) 1 YEAR OF CONTINUOUS ELIGIBILITY FOR CHILDREN.—The State plan (or waiver of such State plan) shall provide that an individual who is under the age of 19 and who is determined to be eligible for benefits under a State plan (or waiver of such plan) approved under this subchapter under subsection (a)(10)(A) shall remain eligible for such benefits until the earlier of—

(A) the end of the 12-month period beginning on the date of such determination;

(B) the time that such individual attains the age of 19; or

(C) the date that such individual ceases to be a resident of such State.

(13) EXPRESS LANE OPTION.—

(A) IN GENERAL.—

(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this subchapter for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this subchapter. The State may rely on a finding from an Express Lane agency notwithstanding sections 1396a(a)(46)(B) and 1320b–7(d) of this title or any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.—If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this subchapter and for child health assistance under subchapter XXI, the State shall determine eligibility for assistance using its regular procedures.

(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this subchapter or child health assistance under subchapter XXI and who is subject to premiums based on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll) before enrolling a child in child health assistance

under subchapter XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

(IV) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1396a(a)(46)(B) or 1397ee(c)(9) of this title, as applicable for verifications of citizenship or nationality status.

(V) CODING.—The State meets the requirements of subparagraph (E).

(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

(i) to limit or prohibit a State from taking any actions otherwise permitted under this subchapter or subchapter XXI in determining eligibility for or enrolling children into medical assistance under this subchapter or child health assistance under subchapter XXI; or

(ii) to modify the limitations in section 1396a(a)(5) of this title concerning the agencies that may make a determination of eligibility for medical assistance under this subchapter.

(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this subchapter or for child health assistance under subchapter XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii) ESTABLISHING A SCREENING THRESHOLD.—

(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this subchapter to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this subchapter.

(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this subchapter regardless of whether such child would otherwise satisfy such criteria.

(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 1397jj(b)(4) of this title and to satisfy the requirement under section 1397jj(b)(1)(C) of this title (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under subchapter XXI, the State shall provide the parent, guardian, or custodial relative with the following:

(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this subchapter if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this subchapter using such regular procedures.

(bb) A description of differences between the medical assistance provided under this subchapter and child health assistance under subchapter XXI, including differences in cost-sharing requirements and covered benefits.

(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under subchapter XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under subchapter XXI or for medical assistance under this subchapter in accordance with this clause.

(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this subchapter or child health assistance under subchapter XXI pursuant to subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll).

(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PE-

RIOD.—Medical assistance for items and services that are provided to a child enrolled in subchapter XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such subchapter.

(D) OPTION FOR AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary or by signature on an Express Lane agency application, if the requirement of clause (ii) is met.

(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1396k(a) of this title) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

(i) IN GENERAL.—For purposes of subparagraph (A)(iv),[11] the requirement of this subparagraph for a State is that the State agrees to—

(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's election under this paragraph;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State elects to apply this paragraph, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1396b(a) of this title for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1396b(u) of this title, for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(iv) ERROR RATE DEFINED.—In this subparagraph, the term ''error rate'' means the rate of erroneous excess payments for medical assistance (as defined in section 1396b(u)(1)(D) of this title) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under subchapter XXI, there shall be substituted for references to provisions of this subchapter corresponding provisions within subchapter XXI.

(F) EXPRESS LANE AGENCY.—

(i) IN GENERAL.—In this paragraph, the term ''Express Lane agency'' means a public agency that—

(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

(II) is identified in the State Medicaid plan or the State CHIP plan; and

(III) notifies the child's family—

(aa) of the information which shall be disclosed in accordance with this paragraph;

[11] So in original. Probably should be ''subparagraph (A)(i)(V),''.

(bb) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(cc) that the family may elect to not have the information disclosed for such purposes; and

(IV) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(ii) INCLUSION OF SPECIFIC PUBLIC AGENCIES AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Such term includes the following:

(I) A public agency that determines eligibility for assistance under any of the following:

(aa) The temporary assistance for needy families program funded under part A of subchapter IV.

(bb) A State program funded under part D of subchapter IV.

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

(ee) The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(ff) The Head Start Act [42 U.S.C. 9831 et seq.].

(gg) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(hh) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(ii) The Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.].

(jj) The Stewart B. McKinney Homeless Assistance Act[1] (42 U.S.C. 11301 et seq.).

(kk) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

(*ll*) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

(II) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(III) A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1320b–9(c) of this title).

(iii) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under subchapter XX or a private, for-profit organization.

(iv) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

(I) exempting a State Medicaid agency from complying with the requirements of section 1396a(a)(4) of this title relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest);[12] or

(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(v) ADDITIONAL DEFINITIONS.—In this paragraph:

(I) STATE.—The term ''State'' means 1 of the 50 States or the District of Columbia.

(II) STATE CHIP AGENCY.—The term ''State CHIP agency'' means the State agency responsible for administering the State CHIP plan.

(III) STATE CHIP PLAN.—The term ''State CHIP plan'' means the State child health plan established under subchapter XXI and includes any waiver of such plan.

(IV) STATE MEDICAID AGENCY.—The term ''State Medicaid agency'' means the State agency responsible for administering the State Medicaid plan.

(V) STATE MEDICAID PLAN.—The term ''State Medicaid plan'' means the State plan established under subchapter XIX and includes any waiver of such plan.

(G) CHILD DEFINED.—For purposes of this paragraph, the term ''child'' means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

(I) APPLICATION.—This paragraph shall not apply with respect to eligibility determinations made after September 30, 2029.

(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the

[12] So in original. The closing parenthesis probably should not appear.

effective income eligibility levels that applied under the State plan or waiver on March 23, 2010. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) EXCEPTIONS.—

(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under subchapter XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of paragraph (3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1395w–114 of this title made by the State pursuant to section 1396u–5(a)(2) of this title.

(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1396n of this title or a waiver under section 1315 of this title, and services described in section 1396p(c)(1)(C)(ii) of this title.

(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on March 23, 2010. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children

who would have been eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, no longer being eligible for such assistance.

(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1396n(h)(2)(B) of this title) under the State plan or under a waiver of the plan and under subchapter XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

(G) DEFINITIONS OF MODIFIED ADJUSTED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms ''modified adjusted gross income'' and ''household income'' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

(i) the requirement under this subchapter and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

(ii) any rules established under this subchapter or under the State plan or a waiver of the plan regarding sources of countable income.

(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

(J) EXCLUSION OF PARENT MENTOR COMPENSATION FROM INCOME DETERMINATION.—Any nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor (as defined in paragraph (5) of section 1397mm(f) of this title) in an activity or program funded through a grant under such section shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(K) TREATMENT OF CERTAIN LOTTERY WINNINGS AND INCOME RECEIVED AS A LUMP SUM.—

(i) IN GENERAL.—In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to $80,000 but less than $90,000;

(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and

(IV) over a period of 3 months plus 1 additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

(ii) COUNTING IN EQUAL INSTALLMENTS.—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

(iii) HARDSHIP EXEMPTION.—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

(iv) NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)—

(I) before the date on which the individual loses such eligibility, inform the individual—

(aa) of the individual's opportunity to enroll in a qualified health plan offered

through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

(v) QUALIFIED LOTTERY WINNINGS DEFINED.—In this subparagraph, the term ''qualified lottery winnings'' means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term ''qualified lump sum income'' means income that is received as a lump sum from monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section 1955(b)(4) of title 18).

(15) EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first $2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1382a(b)(26) of this title shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(16) EXTENDING CERTAIN COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(A) IN GENERAL.—At the option of the State, the State plan (or waiver of such State plan) may provide, that an individual who, while pregnant, is eligible for and has received medical assistance under the State plan approved under this subchapter (or a waiver of such plan) (including during a period of retroactive eligibility under subsection (a)(34)) shall, in addition to remaining eligible under paragraph (5) for all pregnancy-related and postpartum medical assistance available under the State plan (or waiver) through the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends, remain eligible under the State plan (or waiver) for medical assistance for the period beginning on the first day occurring after the end of such 60-day period and ending on the last day of the month in which the 12-month period (beginning on the last day of her pregnancy) ends.

(B) FULL BENEFITS DURING PREGNANCY AND THROUGHOUT THE 12-MONTH POSTPARTUM PERIOD.—The medical assistance provided for a pregnant or postpartum individual by a State making an election under this paragraph, without regard to the basis on which the individual is eligible for medical assistance under the State plan (or waiver), shall—

(i) include all items and services covered under the State plan (or waiver) that are not less in amount, duration, or scope, or are determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in subsection (a)(10)(A)(i); and

(ii) be provided for the individual while pregnant and during the 12-month period that begins on the last day of the individual's pregnancy and ends on the last day of the month in which such 12-month period ends.

(C) COVERAGE UNDER CHIP.—A State making an election under this paragraph that covers under subchapter XXI child health assistance for targeted low-income children who are pregnant or targeted low-income pregnant women, as applicable, shall also make the election under section 1397gg(e)(1)(J) of this title.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) and section 1382h(b)(3) of this title and section 1396r–5 of this title, except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1), no State not eligible to participate in the State plan program established under subchapter XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be consid-

ered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions

In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

(h) Payments for hospitals serving disproportionate number of low-income patients and for home and community care

(1) Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care, home and community-based services provided under subsection (c), (d), or (i) of section 1396n of this title or under a waiver or demonstration project under section 1315 of this title, self-directed personal assistance services provided pursuant to a written plan of care under section 1396n(j) of this title, and home and community-based attendant services and supports under section 1396n(k) of this title.

(2) Nothing in this subchapter, subchapter XVIII, or subchapter XI shall be construed as prohibiting receipt of any care or services specified in paragraph (1) in an acute care hospital that are—

(A) identified in an individual's person-centered service plan (or comparable plan of care);

(B) provided to meet needs of the individual that are not met through the provision of hospital services;

(C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

(D) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

(i) Termination of certification for participation of and suspension of State payments to intermediate care facilities for the mentally retarded

(1) In addition to any other authority under State law, where a State determines that a[13] intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this subchapter, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this subchapter, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Waiver or modification of subchapter requirements with respect to medical assistance program in American Samoa

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in

[13] So in original. Probably should be ''an''.

American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(f) of this title,,[6] the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of section 1396d(a) of this title, or the requirement under subsection (qq)(1) (relating to data reporting).

(k) Minimum coverage for individuals with income at or below 133 percent of the poverty line

(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1396u–7(b)(1) of this title or benchmark equivalent coverage described in section 1396u–7(b)(2) of this title. Such medical assistance shall be provided subject to the requirements of section 1396u–7 of this title, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1396u–7(a)(2) of this title, the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1396u–7 of this title or benchmark equivalent coverage described in subsection (b)(2) of that section.

(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2),[14] the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ''parent'' includes an individual treated as a caretaker relative for purposes of carrying out section 1396u–1 of this title.

***(l)* Description of group**

(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income 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.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of July 1, 1988, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of July 1, 1988, or

(II) if no such percentage is specified as of July 1, 1988, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of December 19, 1989, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of December 19, 1989, or

(II) if no such percentage is specified as of December 19, 1989, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of

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

such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent (or, beginning January 1, 2014, 133 percent) of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under subchapter XVI;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of subchapter IV;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of subchapter IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)(A) 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 provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m) Description of individuals

(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1382c(a)(3) 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)(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (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) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) 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 subsection (a)(10)(A).

(C) The provisions of section 1396d(p)(2)(D) of this title shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1396d(p) of this title.

(3) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1396d(p)(1) of this title—

(A) the income standard to be applied is the income standard described in section 1396d(p)(1)(B) of this title, and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(n) Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing

respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under subchapter XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396b(m)(1)(A) of this title for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

(*o*) Certain benefits disregarded for purposes of determining post-eligibility contributions

Notwithstanding any provision of subsection (a) to the contrary, a State plan under this subchapter shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1382(e)(1) of this title to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p) Exclusion power of State; exclusion as prerequisite for medical assistance payments; "exclude" defined

(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII under section 1320a–7, 1320a–7a, or 1395cc(b)(2) of this title.

(2) In order for a State to receive payments for medical assistance under section 1396b(a) of this title, with respect to payments the State makes to a medicaid managed care organization (as defined in section 1396b(m) of this title) or to an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title, the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1320a–7(b)(8) of this title (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1320a–7(b)(8)(B) of this title, or

(C) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a–7 or 1320a–7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term ''exclude'' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q) Minimum monthly personal needs allowance deduction; "institutionalized individual or couple" defined

(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term ''institutionalized individual or couple'' means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing fa-

cility for which payments are made under this subchapter throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph[15] is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r) Disregarding payments for certain medical expenses by institutionalized individuals

(1)(A) For purposes of sections 1396a(a)(17) and 1396r–5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this subchapter, a veteran's pension in excess of $90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be ''no more restrictive'' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years

In order to meet the requirements of subsection (a)(55)[16], the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1396r–4(b)(1) of this title, shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Limitation on payments to States for expenditures attributable to taxes

Nothing in this subchapter (including sections 1396b(a) and 1396d(a) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u) Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 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,

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not

[15] So in original. Probably should be ''this subsection''.

[16] So in original. Probably should be subsection ''(a)(56)''.

exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this subchapter resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) and this subsection, the term ''COBRA premiums'' means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term ''COBRA continuation coverage'' means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], section 4980B of the Internal Revenue Code of 1986, or title VI[1] of the Employee Retirement Income Security Act of 1974.

(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.

(v) State agency disability and blindness determinations for medical assistance eligibility

A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1382c(a) of this title.

(w) Maintenance of written policies and procedures respecting advance directives

(1) For purposes of subsection (a)(57) and sections 1396b(m)(1)(A) and 1396r(c)(2)(E) of this title, the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a medicaid managed care organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term ''advance directive'' means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(5) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(x) Physician identifier system; establishment

The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this subchapter.

(y) Intermediate sanctions for psychiatric hospitals

(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1396d(h) of this title) and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this subchapter—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1396b(a) of this title with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this subchapter.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z) Optional coverage of TB-related services

(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i)—

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this subchapter with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this subchapter with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10), the term ''TB-related services'' means each of the following services relating to treatment of infection with tuberculosis:

(A) Prescribed drugs.

(B) Physicians' services and services described in section 1396d(a)(2) of this title.

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in section 1396n(g)(2) of this title).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.

(aa) Certain breast or cervical cancer patients

Individuals described in this subsection are individuals who—

(1) are not described in subsection (a)(10)(A)(i);

(2) have not attained age 65;

(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

(4) are not otherwise covered under creditable coverage, as defined in section 2701(c)[1] of the Public Health Service Act (42 U.S.C. 300gg(c)), but applied without regard to paragraph (1)(F) of such section.

(bb) Payment for services provided by Federally-qualified health centers and rural health clinics

(1) In general

Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by a Federally-qualified health center and services described in section 1396d(a)(2)(B) of this title furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable

and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395*l*(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395*l*(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years

Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics

In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by the center or services described in section 1396d(a)(2)(B) of this title furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care

(A) In general

In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) Payment schedule

The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies

Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1396d(a)(2)(C) of this title or to a rural health clinic for services described in section 1396d(a)(2)(B) of this title in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

(cc) Disabled children eligible to receive medical assistance at option of State

(1) Individuals described in this paragraph are individuals—

(A) who are children who have not attained 19 years of age and are born—

(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

(B) who would be considered disabled under section 1382c(a)(3)(C) of this title (as determined under subchapter XVI for children but without regard to any income or asset eligibility requirements that apply under such subchapter with respect to children); and

(C) whose family income does not exceed such income level as the State establishes and does not exceed—

(i) 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved; or

(ii) such higher percent of such poverty line as a State may establish, except that—

(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

(II) no Federal financial participation shall be provided under section 1396b(a) of this title for any medical assistance provided to such an individual.

(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act [42 U.S.C. 300gg–91(a)]), the State shall—

(i) notwithstanding section 1396e of this title, require such parent to apply for, enroll

in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

(ii) if such coverage is obtained—

(I) subject to paragraph (2) of section 1396*o*(h)[17] of this title, reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

(II) treat such coverage as a third party liability under subsection (a)(25).

(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding section 1396e of this title but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(dd) Electronic transmission of information

If the State agency determining eligibility for medical assistance under this subchapter or child health assistance under subchapter XXI verifies an element of eligibility based on information from an Express Lane Agency[18] (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1320b–7(d)(2) of this title may be met through evidence in digital or electronic form.

(ee) Alternate State process for verification of citizenship or nationality declaration

(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this subchapter, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1396b(x) of this title (if the individual is not described in paragraph (2) of that section), as follows:

(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the program established under paragraph (2).

(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is inconsistent with information in the records maintained by the Commissioner—

(i) the State makes a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number submitted or declaration of citizenship or nationality and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

(ii) in the case such inconsistency is not resolved under clause (i), the State—

(I) notifies the individual of such fact;

(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1396b(x)(3) of this title) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

(III) disenrolls the individual from the State plan under this subchapter within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such inconsistency is not resolved.

(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1396a(a)(46)(B) of this title shall establish a program under which the State submits at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this subchapter that month who is not described in section 1396b(x)(2) of this title and who declares to be a United States citizen or national, with information in records maintained by the Commissioner.

(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security—

(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information submitted under subparagraph (A) for an individual enrolled in the State plan under this subchapter who declares to be[19] citizen or national on at least a monthly basis; or

(ii) to provide for a determination of the consistency of the information submitted with the information maintained in the records of the Commissioner through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i).

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social secu-

[17] So in original. Probably should be section ''1396*o*(i)''.

[18] So in original. Probably should be ''agency''.

[19] So in original. Probably should be followed by ''a''.

rity number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1396b(x)(3) of this title) as is provided under clauses (i) and (ii) of section 1320b–7(d)(4)(A) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(3)(A) The State agency implementing the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the inconsistent submissions bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if—

(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

(ii) the inconsistency is not resolved by the State;

(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

(iv) payment has been made for an item or service furnished to the individual under this subchapter.

(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent—

(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this subchapter and to identify and implement changes in such procedures to improve their accuracy; and

(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

(4) Nothing in this subsection shall affect the rights of any individual under this subchapter to appeal any disenrollment from a State plan.

(ff) Disregard of certain property in determination of eligibility of Indians

Notwithstanding any other requirement of this subchapter or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this subchapter:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act [43 U.S.C. 1601 et seq.], and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(gg) Maintenance of effort

(1) General requirement to maintain eligibility standards until State exchange is fully operational

Subject to the succeeding paragraphs of this subsection, during the period that begins on March 23, 2010, and ends on the date on which the Secretary determines that an Exchange established by the State under section 18031 of this title is fully operational, as a condition for receiving any Federal payments under section 1396b(a) of this title for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on March 23, 2010.

(2) Continuation of eligibility standards for children through September 30, 2029

The requirement under paragraph (1) shall continue to apply to a State through September 30, 2029, (but during the period that begins on October 1, 2019, and ends on September 30, 2029, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section

1397jj(c)(5) of this title) applicable to a family of the size involved) with respect to the eligibility standards, methodologies, and procedures under the State plan under this subchapter or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

(3) Nonapplication

During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4) Determination of compliance

(A) States shall apply modified adjusted gross income

A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(B) States may expand eligibility or move waivered populations into coverage under the State plan

With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on March 23, 2010, or that makes individuals who, on March 23, 2010, are eligible for medical assistance under a waiver of the State plan, after March 23, 2010, eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of subsection (a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(hh) State option for coverage for individuals with income that exceeds 133 percent of the poverty line

(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ''parent'' includes an individual treated as a caretaker relative for purposes of carrying out section 1396u–1 of this title.

(ii) State eligibility option for family planning services

(1) Individuals described in this subsection are individuals—

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this subchapter (or under its State child health plan under subchapter XXI) for pregnant women; and

(B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XVI) of the matter following subparagraph (G) of section[20] subsection (a)(10) pursuant to a waiver granted under section 1315 of this title.

(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.

(jj) Primary care services defined

For purposes of subsection (a)(13)(C), the term ''primary care services'' means—

(1) evaluation and management services that are procedure codes (for services covered under subchapter XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section

[20] So in original. The word ''section'' probably should not appear.

1395w–4(c)(5) of this title as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.

(kk) Provider and supplier screening, oversight, and reporting requirements

For purposes of subsection (a)(77), the requirements of this subsection are the following:

(1) Screening

The State complies with the process for screening providers and suppliers under this subchapter, as established by the Secretary under section 1395cc(j)(2) of this title.

(2) Provisional period of enhanced oversight for new providers and suppliers

The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this subchapter, as established by the Secretary under section 1395cc(j)(3) of this title.

(3) Disclosure requirements

The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1395cc(j)(5) of this title.

(4) Temporary moratorium on enrollment of new providers or suppliers

(A) Temporary moratorium imposed by the Secretary

(i) In general

Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1395cc(j)(7) of this title.

(ii) Exceptions

(I) Compliance with moratorium

A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

(II) FFP available

Notwithstanding section 1396b(i)(2)(E) of this title, payment may be made to a State under this subchapter with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this subchapter (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.

(iii) Limitation on charges to beneficiaries

With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1395cc(j)(7) of this title from charging an individual or other person eligible to receive medical assistance under the State plan under this subchapter (or a waiver of the plan) for an item or service described in section 1396b(i)(2)(E) of this title furnished to such an individual.

(B) Moratorium on enrollment of providers and suppliers

At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

(5) Compliance programs

The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1395cc(j)(7)[1] of this title, a compliance program that contains the core elements established under subparagraph (B) of that section 1395cc(j)(7)[1] of this title for providers or suppliers within a particular industry or category.

(6) Reporting of adverse provider actions

The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

(7) Enrollment and NPI of ordering or referring providers

The State requires—

(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

(8) Provider terminations

(A) In general

Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider

of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 30 days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

(i) the name of such provider or person;

(ii) the provider type of such provider or person;

(iii) the specialty of such provider's or person's practice;

(iv) the date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);

(v) the reason for the termination;

(vi) a copy of the notice of termination sent to the provider or person;

(vii) the date on which such termination is effective, as specified in the notice; and

(viii) any other information required by the Secretary.

(B) Effective date defined

For purposes of this paragraph, the term ''effective date'' means, with respect to a termination described in subparagraph (A), the later of—

(i) the date on which such termination is effective, as specified in the notice of such termination; or

(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.

(9) Other State oversight

Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

(*ll*) Termination notification database

In the case of a provider of services or any other person whose participation under this subchapter or subchapter XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).

(mm) Directory physician or provider described

A physician or provider described in this subsection is—

(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that—

(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

(B) received payment under the State plan in the 12-month period preceding such date; and

(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).

(nn) Juvenile; eligible juvenile; public institution

For purposes of subsection (a)(84) and this subsection:

(1) Juvenile

The term ''juvenile'' means an individual who is—

(A) under 21 years of age; or

(B) described in subsection (a)(10)(A)(i)(IX).

(2) Eligible juvenile

The term ''eligible juvenile'' means a juvenile who is an inmate of a public institution and who—

(A) was determined eligible for medical assistance under the State plan (or waiver of such plan) immediately before becoming an inmate of such a public institution; or

(B) is determined eligible for such medical assistance while an inmate of a public institution.

(3) Inmate of a public institution

The term ''inmate of a public institution'' has the meaning given such term for purposes of applying the subdivision (A) following the last numbered paragraph of section 1396d(a) of this title, taking into account the exception in such subdivision for a patient of a medical institution.

(*oo*) Drug review and utilization requirements

(1) In general

For purposes of subsection (a)(85), the drug review and utilization requirements under this subsection are, subject to paragraph (3) and beginning October 1, 2019, the following:

(A) Claims review limitations

(i) In general

The State has in place—

(I) safety edits (as specified by the State) for subsequent fills for opioids and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the State plan (or under a waiver of the State plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the State;

(II) safety edits (as specified by the State) on the maximum daily morphine equivalent that can be prescribed to an individual enrolled under the State plan

(or under a waiver of the State plan) for treatment of chronic pain and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any limitation that may be identified by the State; and

(III) a claims review automated process (as designed and implemented by the State) that monitors when an individual enrolled under the State plan (or under a waiver of the State plan) is concurrently prescribed opioids and—

(aa) benzodiazepines; or

(bb) antipsychotics.

(ii) Managed care entities

The State requires each managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) with respect to which the State has a contract under section 1396b(m) of this title or under section 1396d(t)(3) of this title to have in place, subject to paragraph (3), with respect to individuals who are eligible for medical assistance under the State plan (or under a waiver of the State plan) and who are enrolled with the entity, the limitations described in subclauses (I) and (II) of clause (i) and a claims review automated process described in subclause (III) of such clause.

(iii) Rules of construction

Nothing in this subparagraph may be construed as prohibiting a State or managed care entity from designing and implementing a claims review automated process under this subparagraph that provides for prospective or retrospective reviews of claims. Nothing in this subparagraph shall be understood as prohibiting the exercise of clinical judgment from a provider enrolled as a participating provider in a State plan (or waiver of the State plan) or contracting with a managed care entity regarding the best items and services for an individual enrolled under such State plan (or waiver).

(B) Program to monitor antipsychotic medications by children

The State has in place a program (as designed and implemented by the State) to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the State plan (or under a waiver of the State plan) and submits annually to the Secretary such information as the Secretary may require on activities carried out under such program for individuals not more than the age of 18 years generally and children in foster care specifically.

(C) Fraud and abuse identification

The State has in place a process (as designed and implemented by the State) that identifies potential fraud or abuse of controlled substances by individuals enrolled under the State plan (or under a waiver of the State plan), health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

(D) Reports

The State shall include in the annual report submitted to the Secretary under section 1396r–8(g)(3)(D) of this title information on the limitations, requirement, program, and processes applied by the State under subparagraphs (A) through (C) in accordance with such manner and time as specified by the Secretary.

(E) Clarification

Nothing shall prevent a State from satisfying the requirement—

(i) described in subparagraph (A) by having safety edits or a claims review automated process described in such subparagraph that was in place before October 1, 2019;

(ii) described in subparagraph (B) by having a program described in such subparagraph that was in place before such date; or

(iii) described in subparagraph (C) by having a process described in such subparagraph that was in place before such date.

(2) Annual report by Secretary

For each fiscal year beginning with fiscal year 2020, the Secretary shall submit to Congress a report on the most recent information submitted by States under paragraph (1)(D).

(3) Exceptions

(A) Certain individuals exempted

The drug review and utilization requirements under this subsection shall not apply with respect to an individual who—

(i) is receiving—

(I) hospice or palliative care; or

(II) treatment for cancer;

(ii) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(iii) the State elects to treat as exempted from such requirements.

(B) Exception relating to ensuring access

In order to ensure reasonable access to health care, the Secretary shall waive the drug review and utilization requirements under this subsection, with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1395w–104(c)(5)(D)(ii)(II) of this title).

(pp) Residential pediatric recovery center defined

(1) In general

For purposes of section 1396a(a)(86) of this title, the term ''residential pediatric recovery center'' means a center or facility that fur-

nishes items and services for which medical assistance is available under the State plan to infants with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors.

(2) Counseling and services

A residential pediatric recovery center may offer counseling and other services to mothers (and other appropriate family members and caretakers) of infants receiving treatment at such centers if such services are otherwise covered under the State plan under this subchapter or under a waiver of such plan. Such other services may include the following:

(A) Counseling or referrals for services.

(B) Activities to encourage caregiver-infant bonding.

(C) Training on caring for such infants.

(qq) Application of certain data reporting and program integrity requirements to Northern Mariana Islands, American Samoa, and Guam

(1) In general

Not later than October 1, 2021, the Northern Mariana Islands, American Samoa, and Guam shall—

(A) demonstrate progress in implementing methods, satisfactory to the Secretary, for the collection and reporting of reliable data to the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system); and

(B) demonstrate progress in establishing a State medicaid fraud control unit described in section 1396b(q) of this title.

(2) Determination of progress

For purposes of paragraph (1), the Secretary shall deem that a territory described in such paragraph has demonstrated satisfactory progress in implementing methods for the collection and reporting of reliable data or establishing a State medicaid fraud control unit if the territory has made a good faith effort to implement such methods or establish such a unit, given the circumstances of the territory.

(rr) Program integrity requirements for Puerto Rico

(1) System for tracking Federal Medicaid funding provided to Puerto Rico

(A) In general

Puerto Rico shall establish and maintain a system, which may include the use of a quarterly Form CMS–64, for tracking any amounts paid by the Federal Government to Puerto Rico with respect to the State plan of Puerto Rico (or a waiver of such plan). Under such system, Puerto Rico shall ensure that information is available, with respect to each quarter in a fiscal year (beginning with the first quarter beginning on or after the date that is 1 year after December 20, 2019), on the following:

(i) In the case of a quarter other than the first quarter of such fiscal year—

(I) the total amount expended by Puerto Rico during any previous quarter of such fiscal year under the State plan of Puerto Rico (or a waiver of such plan); and

(II) a description of how such amount was so expended.

(ii) The total amount that Puerto Rico expects to expend during the quarter under the State plan of Puerto Rico (or a waiver of such plan), and a description of how Puerto Rico expects to expend such amount.

(B) Report to CMS

For each quarter with respect to which Puerto Rico is required under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the Centers for Medicare & Medicaid Services a report on such information for such quarter, which may include the submission of a quarterly Form CMS–37.

(2) Submission of documentation on contracts upon request

Puerto Rico shall, upon request, submit to the Administrator of the Centers for Medicare & Medicaid Services all documentation requested with respect to contracts awarded under the State plan of Puerto Rico (or a waiver of such plan).

(3) Reporting on Medicaid and CHIP Scorecard measures

Beginning 12 months after December 20, 2019, Puerto Rico shall begin to report to the Administrator of the Centers for Medicare & Medicaid Services on selected measures included in the Medicaid and CHIP Scorecard developed by the Centers for Medicare & Medicaid Services.

(ss) Uninsured individual defined

For purposes of this section, the term ''uninsured individual'' means, notwithstanding any other provision of this subchapter, any individual who is—

(1) not described in subsection (a)(10)(A)(i) (excluding subclause (VIII) of such subsection if the individual is a resident of a State which does not furnish medical assistance to individuals described in such subclause); and

(2) not enrolled in a Federal health care program (as defined in section 1320a–7b(f) of this title), a group health plan, group or individual health insurance coverage offered by a health insurance issuer (as such terms are defined in section 300gg–91 of this title), or a health plan offered under chapter 89 of title 5, except that individuals who are eligible for medical assistance under subsection (a)(10)(A)(ii)(XII), subsection (a)(10)(A)(ii)(XVIII), subsection (a)(10)(A)(ii)(XXI), or subsection (a)(10)(C) (but only to the extent such an individual is considered to not have minimum essential coverage under section 5000A(f)(1) of the Internal Revenue Code of 1986), or who are described in subsection (*l*)(1)(A) and are eligible for medical assistance only because of subsection (a)(10)(A)(i)(IV) or (a)(10)(A)(ii)(IX) and whose eligibility for such assistance is limited by the State under clause (VII) in the matter following subsection (a)(10)(G), shall not be treat-

ed as enrolled in a Federal health care program for purposes of this paragraph.

(tt) Requirements relating to transition from Families First Coronavirus Response Act FMAP increase requirements; enforcement and corrective action

(1) Reporting requirements

For each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024, each State shall submit to the Secretary, on a timely basis, a report, that the Secretary shall make publicly available, on the activities of the State relating to eligibility redeterminations conducted during such period, and which include, with respect to the month for which the report is submitted, the following information:

(A) The number of eligibility renewals initiated, beneficiaries renewed on a total and ex parte basis, and individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was terminated.

(B) The number of individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was so terminated for procedural reasons.

(C) Where applicable, the number of individuals who were enrolled in a State child health plan or waiver in the form described in paragraph (1) of section 1397aa(a) of this title.

(D) Unless the Administrator of the Centers for Medicare & Medicaid Services reports such information on behalf of the State:

(i) In a State with a Federal or State American Health Benefit Exchange established under title I of the Patient Protection and Affordable Care Act in which the systems used to determine eligibility for assistance under this subchapter or subchapter XXI are not integrated with the systems used to determine eligibility for coverage under a qualified health plan with advance payment under section 1412(a) of the Patient Protection and Affordable Care Act [42 U.S.C. 18082(a)] of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986—

(I) the number of individuals whose accounts were received via secure electronic transfer by the Federal or State American Health Benefit Exchange, or a basic health program established under section 1331 of the Patient Protection and Affordable Care Act [42 U.S.C. 18051];

(II) the number of individuals identified in subclause (I) who were determined eligible for a qualified health plan, as defined in section 1301(a)(1) of the Patient Protection and Affordable Care Act [42 U.S.C. 18021(a)(1)], or (if applicable) the basic health program established under section 1331 of such Act [42 U.S.C. 18051]; and

(III) the number of individuals identified in subclause (II) who made a qualified health plan selection or were enrolled in a basic health program plan (if applicable).

(ii) In a State with a State American Health Benefit Exchange established under title I of the Patient Protection and Affordable Care Act in which the systems used to determine eligibility for assistance under this subchapter or subchapter XXI are integrated with the systems used to determine eligibility for coverage under a qualified health plan with advance payment under section 1412(a) of the Patient Protection and Affordable Care Act [42 U.S.C. 18082(a)] of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986—

(I) the number of individuals who were determined eligible for a qualified health plan, as defined in section 1301(a)(1) of the Patient Protection and Affordable Care Act [42 U.S.C. 18021(a)(1)], or (if applicable) the basic health program established under section 1331 of such Act [42 U.S.C. 18051]; and

(II) the number of individuals identified in subclause (I) who made a qualified health plan selection or were enrolled in a basic health program plan (if applicable).

(E) The total call center volume, average wait times, and average abandonment rate (as determined by the Secretary) for each call center of the State agency responsible for administering the State plan under this subchapter (or a waiver of such plan) during such month.

(F) Such other information related to eligibility redeterminations and renewals during the period described in paragraph (1), as identified by the Secretary.

(2) Enforcement and corrective action

(A) In general

For each fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, if a State does not satisfy the requirements of paragraph (1), the Federal medical assistance percentage determined for the State for the quarter under section 1396d(b) of this title shall be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the State has failed to satisfy such requirements.

(B) Corrective action plan; additional authority

(i) In general

The Secretary may assess a State's compliance with all Federal requirements applicable to eligibility redeterminations and the reporting requirements described in paragraph (1), and, if the Secretary determines that a State did not comply with any such requirements during the period that begins on April 1, 2023, and ends on June 30, 2024, the Secretary may require the State to submit and implement a corrective action plan in accordance with clause (ii).

(ii) Corrective action plan

A State that receives a written notice from the Secretary that the Secretary has determined that the State is not in compliance with a requirement described in clause (i) shall—

(I) not later than 14 days after receiving such notice, submit a corrective action plan to the Secretary;

(II) not later than 21 days after the date on which such corrective action plan is submitted to the Secretary, receive approval for the plan from the Secretary; and

(III) begin implementation of such corrective action plan not later than 14 days after such approval.

(iii) Effect of failure to submit or implement a corrective action plan

If a State fails to submit or implement an approved corrective action plan in accordance with clause (ii), the Secretary may, in addition to any reduction applied under subparagraph (A) to the Federal medical assistance percentage determined for the State and any other remedy available to the Secretary for the purpose of carrying out this subchapter, require the State to suspend making all or some terminations of eligibility for medical assistance from the State plan under this subchapter (including any waiver of such plan) that are for procedural reasons until the State takes appropriate corrective action, as determined by the Secretary, and may impose a civil money penalty of not more than $100,000 for each day a State is not in compliance.

(Aug. 14, 1935, ch. 531, title XIX, §1902, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 344; amended Pub. L. 90–248, title II, §§210(a)(6), 223(a), 224(a), (c)(1), 227(a), 228(a), 229(a), 231, 234(a), 235(a), 236(a), 237, 238, 241(f)(1)–(4), title III, §302(b), Jan. 2, 1968, 81 Stat. 896, 901–906, 908, 911, 917, 929; Pub. L. 91–56, §2(c), (d), Aug. 9, 1969, 83 Stat. 99; Pub. L. 92–223, §4(b), Dec. 28, 1971, 85 Stat. 809; Pub. L. 92–603, title II, §§208(a), 209(a), (b)(1), 221(c)(5), 231, 232(a), 236(b), 237(a)(2), 239(a), (b), 240, 246(a), 249(a), 255(a), 268(a), 274(a), 278(a)(18)–(20), (b)(14), 298, 299A, 299D(b), Oct. 30, 1972, 86 Stat. 1381, 1389, 1410, 1415–1418, 1424, 1426, 1446, 1450, 1452–1454, 1460, 1462; Pub. L. 93–233, §§13(a)(2)–(10), 18(*o*)–(q), (x)(1)–(4), Dec. 31, 1973, 87 Stat. 960–962, 971, 972; Pub. L. 93–368, §9(a), Aug. 7, 1974, 88 Stat. 422; Pub. L. 94–48, §§1, 2, July 1, 1975, 89 Stat. 247; Pub. L. 94–182, title I, §111(a), Dec. 31, 1975, 89 Stat. 1054; Pub. L. 94–552, §1, Oct. 18, 1976, 90 Stat. 2540; Pub. L. 95–142, §§2(a)(3), (b)(1), 3(c)(1), 7(b), (c), 9, 19(b)(2), 20(b), Oct. 25, 1977, 91 Stat. 1176, 1178, 1193, 1195, 1204, 1207; Pub. L. 95–210, §2(c), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 95–559, §14(a)(1), Nov. 1, 1978, 92 Stat. 2140; Pub. L. 96–272, title III, §308(c), June 17, 1980, 94 Stat. 531; Pub. L. 96–499, title IX, §§902(b), 903(b), 905(a), 912(b), 913(c), (d), 914(b)(1), 916(b)(1), 918(b)(1), 962(a), 965(b), Dec. 5, 1980, 94 Stat. 2613, 2615, 2618–2621, 2624, 2626, 2650, 2652; Pub. L. 96–611, §5(b), Dec. 28, 1980, 94 Stat. 3568; Pub. L. 97–35, title XXI, §§2105(c), 2113(m), 2171(a), (b), 2172(a), 2173(a), (b)(1), 2174(a), 2175(a), (d)(1), 2178(b), 2181(a)(2), 2182, 2193(c)(9), Aug. 13, 1981, 95 Stat. 792, 795, 807–809, 811, 814–816, 828; Pub. L. 97–248, title I, §§131(a), (c), formerly (b), 132(a), (c), 134(a), 136(d), 137(a)(3), (b)(7)–(10), (e), 146(a), Sept. 3, 1982, 96 Stat. 367, 369, 370, 373, 375–378, 381, 394; Pub. L. 97–448, title III, §309(a)(8), Jan. 12, 1983, 96 Stat. 2408; Pub. L. 98–369, div. B, title III, §§2303(g)(1), 2314(b), 2335(e), 2361(a), 2362(a), 2363(a)(1), 2367(a), 2368(a), (b), 2373(b)(1)–(10), title VI, §2651(c), July 18, 1984, 98 Stat. 1066, 1079, 1091, 1104, 1105, 1108, 1109, 1111, 1149; Pub. L. 98–378, §20(c), Aug. 16, 1984, 98 Stat. 1322; Pub. L. 98–617, §3(a)(7), (b)(10), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub. L. 99–272, title IX, §§9501(b), (c), 9503(a), 9505(b), (c)(1), (d), 9506(a), 9509(a), 9510(a), 9517(b), 9529(a)(1), (b)(1), title XII, §12305(b)(3), Apr. 7, 1986, 100 Stat. 201, 202, 205, 208–212, 216, 220, 293; Pub. L. 99–509, title IX, §§9320(h)(3), 9401(a)–(e)(1), 9402(a), (b), 9403(a), (c), (e)–(g)(1), (4)(A), 9404(a), 9405, 9406(b), 9407(a), 9408(a), (b), (c)(2), (3), 9431(a), (b)(1), 9433(a), 9435(b)(1), Oct. 21, 1986, 100 Stat. 2016, 2050–2058, 2060, 2061, 2066, 2068, 2069; Pub. L. 99–514, title XVIII, §1895(c)(1), (3)(B), (C), (7), Oct. 22, 1986, 100 Stat. 2935, 2936; Pub. L. 99–570, title XI, §11005(b), Oct. 27, 1986, 100 Stat. 3207–169; Pub. L. 99–643, §§3(b), 7(b), Nov. 10, 1986, 100 Stat. 3575, 3579; Pub. L. 100–93, §§5(a), 7, 8(f), Aug. 18, 1987, 101 Stat. 689, 691, 694; Pub. L. 100–203, title IV, §§4072(d), 4101(a)(1), (2), (b)(1)–(2)(B), (c)(2), (e)(1)–(5), 4102(b)(1), 4104, 4113(a)(2), (b)(1), (2), (c)(1), (2), (d)(2), 4116, 4118(c)(1), (h)(1), (2), (m)(1)(B), (p)(1)–(4), (6)–(8), 4211(b)(1), (h)(1)–(5), 4212(d)(2), (3), (e)(1), 4213(b)(1), 4218(a), title IX, §§9115(b), 9119(d)(1), Dec. 22, 1987, 101 Stat. 1330–117, 1330–140 to 1330–143, 1330–146, 1330–147, 1330–151, 1330–152, 1330–154 to 1330–157, 1330–159, 1330–203, 1330–205, 1330–213, 1330–219, 1330–220, 1330–305, as amended Pub. L. 100–360, title IV, §411(k)(5)(A), (7)(B)–(D), (10)(G)(ii), (iv), (*l*)(3)(H), (J), (8)(C), (n)(2), (4), formerly (3), July 1, 1988, 102 Stat. 791, 794, 796, 803, 805, 807, as amended Pub. L. 100–485, title VI, §608(d)(14)(I), (15)(A), (27)(F)–(H), (28), Oct. 13, 1988, 102 Stat. 2416, 2423; Pub. L. 100–360, title II, §204(d)(3), title III, §§301(a)(1), (e)(2), 302(a), (b)(1), (c)(1), (2), (d)–(e)(3), 303(d), (e), title IV, §411(k)(5)(B), (17)(B), (*l*)(3)(E), (6)(C), (D), July 1, 1988, 102 Stat. 729, 748–753, 762, 763, 792, 800, 803, 804; Pub. L. 100–485, title II, §202(c)(4), title III, §303(a)(2), (b)(1), (d), title IV, §401(d)(1), title VI, §608(d)(15)(B), (16)(C), Oct. 13, 1988, 102 Stat. 2378, 2391, 2392, 2396, 2416, 2418; Pub. L. 100–647, title VIII, §8434(b)(1), (2), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6115(c), 6401(a), 6402(a), (c)(2), 6403(b), (d)(1), 6404(c), 6405(b), 6406(a), 6408(c)(1), (d)(1), (4)(C), 6411(a)(1), (d)(3)(B), (e)(2), Dec. 19, 1989, 103 Stat. 2219, 2258, 2260, 2261, 2263–2265, 2268–2271; Pub. L. 101–508, title IV, §§4401(a)(2), 4402(a)(1), (c), (d)(1), 4501(b), (e)(2), 4601(a)(1), 4602(a), 4603(a), 4604(a), (b), 4701(b)(1), 4704(a), (e)(1), 4708(a), 4711(c)(1), (d), 4713(a), 4715(a), 4723(b), 4724(a), 4732(b)(1), 4751(a), 4752(a)(1)(A), (c)(1), 4754(a), 4755(a)(2), (c)(1), 4801(e)(1)(A), (11)(A), Nov. 5, 1990, 104 Stat. 1388–143, 1388–161, 1388–163 to 1388–173, 1388–186, 1388–187, 1388–190, 1388–192, 1388–194, 1388–195, 1388–204, 1388–206, 1388–208 to 1388–210, 1388–215, 1388–217; Pub. L. 102–234, §§2(b)(1), 3(a), Dec. 12, 1991, 105 Stat. 1799; Pub. L. 103–66, title XIII,

§ 13581(b)(2), 13601(b), 13602(c), 13603(a)–(c), 13611(d)(1), 13622(a)(1), (b), (c), 13623(a), 13625(a), 13631(a), (e)(1), (f)(1), Aug. 10, 1993, 107 Stat. 611, 613, 619, 620, 626, 632, 633, 636, 643, 644; Pub. L. 103–296, title I, § 108(d)(1), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 103–448, title II, § 204(w)(2)(E), Nov. 2, 1994, 108 Stat. 4746; Pub. L. 104–193, title I, §§ 108(k), 114(b)–(d)(1), title IX, § 913, Aug. 22, 1996, 110 Stat. 2169, 2180, 2354; Pub. L. 104–226, § 1(b)(2), Oct. 2, 1996, 110 Stat. 3033; Pub. L. 104–248, § 1(a)(1), Oct. 9, 1996, 110 Stat. 3148; Pub. L. 105–12, § 9(b)(2), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§ 4106(c), 4454(b)(1), 4701(b)(2)(A)(i)–(iv), (d)(1), 4702(b)(2), 4709, 4711(a), 4712(a), (b)(1), (c)(1), 4714(a)(1), 4715(a), 4724(c)(1), (d), (f), (g)(1), 4731(a), (b), 4732(a), 4733, 4741(a), 4751(a), (b), 4752(a), 4753(b), 4911(b), 4912(b)(1), 4913(a), Aug. 5, 1997, 111 Stat. 368, 431, 493, 495, 506–510, 516, 517, 519, 520, 522–525, 571, 573; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, §§ 603(a)(1), 604(a)(1), (2)(A), (b)(1), 608(a)–(d), (y)(2), (aa)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394 to 1501A–398; Pub. L. 106–169, title I, § 121(a)(1), (c)(4), title II, §§ 205(c), 206(b), Dec. 14, 1999, 113 Stat. 1829, 1830, 1834, 1837; Pub. L. 106–170, title II, § 201(a)(1), (2)(A), Dec. 17, 1999, 113 Stat. 1891, 1892; Pub. L. 106–354, § 2(a)(1)–(3), (b)(2)(A), Oct. 24, 2000, 114 Stat. 1381–1383; Pub. L. 106–554, § 1(a)(6) [title VII, §§ 702(a)–(c)(1), 707(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–572 to 2763A–574, 2763A–577; Pub. 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C, title XVII, § 17004(b)(1)(B), (C), (2)(B), Dec. 13, 2016, 130 Stat. 1191–1196, 1332, 1333; Pub. L. 115–120, div. C, §§ 3002(e), (f)(2), 3004(c), Jan. 22, 2018, 132 Stat. 34, 35, 37; Pub. L. 115–123, div. E, title I, § 50101(e), (f)(2), title XII, §§ 53102(a)(1), (b)(1), (d)(2), 53103(a), Feb. 9, 2018, 132 Stat. 174, 175, 298–300; Pub. L. 115–271, title I, §§ 1001(a), 1002(a)(1), 1004(a)(1), (2), 1006(b)(1), 1007(a), (b), Oct. 24, 2018, 132 Stat. 3900, 3902, 3909, 3914, 3915; Pub. L. 116–16, § 7(a), Apr. 18, 2019, 133 Stat. 864; Pub. L. 116–94, div. N, title I, § 202(e)(1), (2), (f)(4), Dec. 20, 2019, 133 Stat. 3108–3110; Pub. L. 116–127, div. F, § 6004(a)(3)(A)–(C), Mar. 18, 2020, 134 Stat. 205, 206; Pub. L. 116–136, div. A, title III, §§ 3715, 3716, Mar. 27, 2020, 134 Stat. 424, 425; Pub. L. 116–260, div. CC, title II, §§ 209(a)(1), (b)(4)(A), 210(b), title IV, § 402(f)(2), Dec. 27, 2020, 134 Stat. 2986, 2988, 2991, 3001; Pub. L. 117–2, title IX, §§ 9811(a)(2), 9812(a), Mar. 11, 2021, 135 Stat. 208, 212; Pub. L. 117–103, div. P, title II, § 202(a), Mar. 15, 2022, 136 Stat. 803; Pub. L. 117–169, title I, § 11405(a)(1), Aug. 16, 2022, 136 Stat. 1900; Pub. L. 117–328, div. FF, title V, §§ 5111(d), 5112(a), 5121(a), 5122(a)(2), 5123(b), 5131(b), Dec. 29, 2022, 136 Stat. 5939–5941, 5944, 5945, 5950; Pub. L. 118–42, div. G, title I, §§ 203(a), 205(a)(1), (c)(1), (2), Mar. 9, 2024, 138 Stat. 403, 405, 406.)

AMENDMENT OF SECTION

Pub. L. 118–42, div. G, title I, § 203, Mar. 9, 2024, 138 Stat. 403, provided that, effective on the date that is 24 months after Mar. 9, 2024, subsection (oo)(1)(B) of this section is amended as follows:

(1) in the subparagraph heading, by striking ''by children'';

(2) by striking ''children enrolled'' and inserting ''children generally, children in foster care specifically, individuals over the age of 18 receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117–2), and individuals over the age of 18 residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings) enrolled''; and

(3) by striking ''not more than the age of 18 years'' through the period at the end and inserting ''subject to the program, including information with respect to each such category of children and individuals over the age of 18.''

See 2024 Amendment note below.

Pub. L. 118–42, div. G, title I, § 205(a)(1)(B)–(F), (2)(B), Mar. 9, 2024, 138 Stat. 405, 406, provided that, effective Jan. 1, 2026, subsection (a)(84)(A) of this section is amended as follows:

(1) by striking ''who is an eligible juvenile (as defined in subsection (nn)(2))'';

(2) by striking ''because the juvenile'' and inserting ''because the individual'';

(3) by striking ''during the period the juvenile'' and inserting ''during the period the individual'';

(4) by inserting ''such an individual who is an eligible juvenile (as defined in subsection (nn)(2)) and'' after ''or in the case of''; and

(5) by striking ''paragraph (31)'' and inserting ''the last numbered paragraph''.

See 2024 Amendment note below.

Pub. L. 117–328, div. FF, title V, § 5123(b), (d), Dec. 29, 2022, 136 Stat. 5945, 5946, provided that, effective July 1, 2025, this section is amended as follows:

(1) in subsection (a), by striking paragraph (83) and inserting the following:

''(83) provide that in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1396n(b)(1) of this title, the State shall publish (and update on at least a quarterly basis or more frequently as required by the Secretary) on the public website of the State agency administering the State plan, a searchable directory of the providers described in subsection (mm) that, in addition to such other requirements as the Secretary may specify, such as making paper directories available to enrollees, includes with respect to each such provider—

''(A) the name of the provider;

''(B) the specialty of the provider;

''(C) the address at which the provider provides services;

''(D) the telephone number of the provider;

''(E) information regarding—

''(i) the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office;

''(ii) whether the provider is accepting as new patients individuals who receive medical assistance under this subchapter;

''(iii) whether the provider's office or facility has accommodations for individuals with physical disabilities, including offices, exam rooms, and equipment;

''(iv) the Internet website of such provider, if applicable; and

''(v) whether the provider offers covered services via telehealth; and

''(F) other relevant information as required by the Secretary;''; and

(2) by striking subsection (mm) and inserting the following:

''(mm) Directory provider described

''(1) In general

''A provider described in this subsection, at a minimum, includes physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports as appropriate, and such other providers as required by the Secretary, and—

''(A) in the case of a provider or a provider type for which the State agency, as a condition of receiving payment for items and services furnished by the provider to individuals eligible to receive medical assistance under the State plan (or a waiver of the plan), requires the enrollment of the provider with the State agency, includes a provider that—

''(i) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

''(ii) received payment under the State plan in the 12-month period preceding such date; and

''(B) in the case of a provider or a provider type for which the State agency does not require such enrollment, includes a provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).

''(2) State option to include other participating providers

''At State option, a provider described in this subsection may include any provider who furnishes services and is participating under the State plan under this subchapter or under a waiver of such plan.''

See 2022 Amendment notes below.

Pub. L. 101–508, title IV, § 4801(e)(11), Nov. 5, 1990, 104 Stat. 1388–217, provided that, effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title, subsection (a)(29) of this section is repealed.

Editorial Notes

REFERENCES IN TEXT

The Child Nutrition Act of 1966, referred to in subsecs. (a)(7) and (e)(13)(F)(ii)(I)(hh), is Pub. L. 89–642, Oct. 11, 1966, 80 Stat. 885, which is classified generally to chapter 13A (§ 1771 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1771 of this title and Tables.

The Richard B. Russell National School Lunch Act, referred to in subsecs. (a)(7) and (e)(13)(F)(ii)(I)(gg), is act June 4, 1946, ch. 281, 60 Stat. 230, which is classified generally to chapter 13 (§ 1751 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1751 of this title and Tables.

Section 602 of this title, referred to in subsecs. (a)(10)(A)(i)(I) and (e)(10), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, § 103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains subsec. (a)(37) or (a)(43).

Section 606 of this title, referred to in subsec. (a)(10)(A)(i)(I), 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. (h).

Section 682 of this title, referred to in subsec. (a)(10)(A)(i)(I), was repealed by Pub. L. 104–193, title I, § 108(e), Aug. 22, 1996, 110 Stat. 2167.

The date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(10)(A)(i)(II)(aa), is the date of enactment of Pub. L. 104–193, which was approved Aug. 22, 1996. Section 211(a) of the Act amended section 1382c of this title.

Section 303(a)(4)(A) of this title, referred to in subsec. (a)(20)(C), was amended generally by Pub. L. 97–35, title XXIII, § 2353(a)(1)(A), Aug. 13, 1981, 95 Stat. 871, and, as so amended, no longer contained cls. (i) and (ii). Section 303(a)(4) was amended by Pub. L. 103–66, title XIII, § 13741(b), Aug. 10, 1993, 107 Stat. 663, and, as so amended, no longer contains subparagraphs.

Section 1383(a)(4)(A)(i) and (ii) of this title, referred to in subsec. (a)(20)(C), is a reference to section 1383(a)(4)(A)(i) and (ii) existing prior to the general revision of subchapter XVI of this chapter by Pub. L. 92–603, title III, § 301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1383 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands. Subsec. (a)(4) of the prior section was amended generally by Pub. L. 97–35, title XXIII, § 2353(m)(2)(B), Aug. 13, 1981, 95 Stat. 973, and, as so amended, no longer contained clauses in subpar. (A). Subsec. (a)(4) of the prior section was also amended by Pub. L. 103–66, title XIII, § 13741(b), Aug. 10, 1993, 107 Stat. 663, and, as so amended, no longer contains subparagraphs.

Section 6401(b)(2) of the Patient Protection and Affordable Care Act, referred to in subsecs. (a)(39) and (*ll*), is section 6401(b)(2) of Pub. L. 111–148, which is set out as a note under section 1395cc of this title.

Public Law 92–336, referred to in provisions following subsec. (a)(81), is Pub. L. 92–336, July 1, 1972, 86 Stat. 406, which amended sections 401, 403, 409, 411, 415, 427, 428, and 430 of this title and sections 165, 1401, 1402, 3101, 3111, 3121, 3122, 3125, 6413, and 6654 of Title 26, Internal Revenue Code, and enacted provisions set out as notes under sections 403, 409, 415, and 428 of this title and sections 165 and 1401 of Title 26.

The Food and Nutrition Act of 2008, referred to in subsec. (e)(13)(F)(ii)(I)(ee), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§ 2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

The Head Start Act, referred to in subsec. (e)(13)(F)(ii)(I)(ff), is subchapter B (§ 635 et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§ 9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (e)(13)(F)(ii)(I)(ii), is subchapter C (§ 658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, as added by Pub. L. 101–508, title V, § 5082(2), Nov. 5, 1990, 104 Stat. 1388–236, which is classified generally to subchapter II–B (§ 9857 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see section 9857(a) of this title and Tables.

The Stewart B. McKinney Homeless Assistance Act, referred to in subsec. (e)(13)(F)(ii)(I)(jj), was Pub. L. 100–77, July 22, 1987, 101 Stat. 482. Pub. L. 100–77 was renamed the McKinney-Vento Homeless Assistance Act by Pub. L. 106–400, § 1, Oct. 30, 2000, 114 Stat. 1675, and is classified principally to chapter 119 (§ 11301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11301 of this title and Tables.

The United States Housing Act of 1937, referred to in subsec. (e)(13)(F)(ii)(I)(kk), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93–383, title II, § 201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§ 1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The Native American Housing Assistance and Self-Determination Act of 1996, referred to in subsec. (e)(13)(F)(ii)(I)(*ll*), is Pub. L. 104–330, Oct. 26, 1996, 110 Stat. 4016, which is classified principally to chapter 43 (§ 4101 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 4101 of Title 25 and Tables.

The Internal Revenue Code of 1986, referred to in subsecs. (e)(14)(G), (K)(iv)(I)(aa), (v), (u)(3), (ss)(2), and (tt)(1)(D)(i), (ii), is classified generally to Title 26, Internal Revenue Code.

The Patient Protection and Affordable Care Act, referred to in subsecs. (e)(14)(K)(iv)(I)(aa) and (tt)(1)(D)(i), (ii), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. Title I of the Act enacted chapter 157 of Title 42, The Public Health and Welfare, and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Public Health Service Act, referred to in subsecs. (u)(3) and (aa)(3), is act July 1, 1944, ch. 373, 58 Stat. 682. Titles XV and XXII of the Act are classified generally to subchapters XIII (§ 300k et seq.) and XX (§ 300bb–1 et seq.), respectively, of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (u)(3), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829. Title VI of the Act probably means part 6 of subtitle B of title I of the Act which is classified generally to part 6 (§ 1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor, because the Act has no title VI. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 2701 of the Public Health Service Act, referred to in subsec. (aa)(4), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 1710(1) of the Government Paperwork Elimination Act, referred to in subsec. (dd), is section 1710(1) of Pub. L. 105–277, which is set out in a note under section 3504 of Title 44, Public Printing and Documents.

The Alaska Native Claims Settlement Act, referred to in subsec. (ff)(1), is Pub. L. 92–203, Dec. 18, 1971, 85 Stat. 688, which is classified generally to chapter 33 (§ 1601 et seq.) of Title 43, Public Lands. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 43 and Tables.

Section 1395cc(j)(7) of this title, referred to in subsec. (kk)(5), was redesignated section 1395cc(j)(9) by Pub. L. 111–152, title I, § 1304(1), Mar. 30, 2010, 124 Stat. 1058 and Pub. L. 114–255, div. C, title XVII, § 17004(b)(2)(A)(ii), Dec. 13, 2016, 130 Stat. 1333.

The Families First Coronavirus Response Act, referred to in subsec. (tt), is Pub. L. 116–127, Mar. 18, 2020, 134 Stat. 178. For complete classification of this Act to the Code, see Short Title note set out under section 2601 of Title 29, Labor, and Tables.

CODIFICATION

In subsec. (a)(4)(D), ''chapter 21 of title 41'' substituted for ''section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423)'' and ''section 2102(a)(3) of title 41'' substituted for ''subsection (a)(2) of such section of that Act'' on authority of Pub. L. 111–350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2024—Subsec. (a)(84)(A). Pub. L. 118–42, § 205(a)(1)(B)–(F), struck out ''who is an eligible juvenile (as defined in subsection (nn)(2))'' after ''under the State plan (or waiver of such plan) for an individual'',

substituted ''because the individual'' for ''because the juvenile'', ''during the period the individual'' for ''during the period the juvenile'', and ''the last numbered paragraph'' for ''paragraph (31)'', and inserted ''such an individual who is an eligible juvenile (as defined in subsection (nn)(2)) and'' after ''or in the case of''.

Pub. L. 118–42, §205(a)(1)(A), substituted ''under the State plan (or waiver of such plan)'' for ''under the State plan''.

Subsec. (nn)(2)(A). Pub. L. 118–42, §205(c)(1), substituted ''State plan (or waiver of such plan)'' for ''State plan''.

Subsec. (nn)(3). Pub. L. 118–42, §205(c)(2), substituted ''the last numbered paragraph'' for ''paragraph (31)''.

Subsec. (*oo*)(1)(B). Pub. L. 118–42, §203(a), in heading, struck out ''by children'' after ''antipsychotic medications'' and, in text, substituted ''children generally, children in foster care specifically, individuals over the age of 18 receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117–2), and individuals over the age of 18 residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings) enrolled'' for ''children enrolled'' and ''subject to the program, including information with respect to each such category of children and individuals over the age of 18.'' for ''not more than the age of 18 years generally and children in foster care specifically.''

2022—Subsec. (a)(10)(A). Pub. L. 117–169, §11405(a)(1)(A), inserted ''(13)(B),'' after ''(5),'' in introductory provisions.

Subsec. (a)(10)(C)(iv). Pub. L. 117–169, §11405(a)(1)(B), inserted '', (13)(B),'' after ''(5)''.

Subsec. (a)(25)(I)(ii). Pub. L. 117–103, §202(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: ''accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;''.

Subsec. (a)(25)(I)(iii). Pub. L. 117–103, §202(a)(2), substituted ''not later than 60 days after receiving any inquiry'' for ''respond to any inquiry'' and '', respond to such inquiry; and'' for ''; and''.

Subsec. (a)(25)(I)(iv). Pub. L. 117–103, §202(a)(3), substituted ''a failure'' for ''or a failure'' and inserted '', or in the case of a responsible third party (other than the original medicare fee-for-service program under parts A and B of subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of such subchapter, a reasonable cost reimbursement plan under section 1395mm of this title, a health care prepayment plan under section 1395*l* of this title, or a prescription drug plan offered by a PDP sponsor under part D of such subchapter) a failure to obtain a prior authorization for the item or service for which the claim is being submitted'' after ''the basis of the claim''.

Subsec. (a)(83). Pub. L. 117–328, §5123(b)(1), added par. (83) and struck out former par. (83) which required a State to publish a directory of physicians for a State plan providing medical assistance on a fee-for-service basis or through a primary care case-management system, and certain other providers at State option, on the public website of the State agency administering the State plan.

Subsec. (a)(84)(A). Pub. L. 117–328, §5122(a)(2), inserted ''(or in the case of a State electing the option described in the subdivision (A) following paragraph (31) of section 1396d(a) of this title, during such period beginning after the disposition of charges with respect to such individual)'' after ''is such an inmate''.

Pub. L. 117–328, §5121(a)(1)(A), inserted '', subject to subparagraph (D),'' after ''but''.

Subsec. (a)(84)(D). Pub. L. 117–328, §5121(a)(1)(B)–(D), added subpar. (D).

Subsec. (e)(12). Pub. L. 117–328, §5112(a), added par. (12) and struck out former par. (12) which read as follows: ''At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this subchapter under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

''(A) the end of a period (not to exceed 12 months) following the determination; or

''(B) the time that the individual exceeds that age.''

Subsec. (e)(13)(I). Pub. L. 117–328, §5111(d)(1), substituted ''2029'' for ''2027''.

Subsec. (gg)(2). Pub. L. 117–328, §5111(d)(2), substituted ''through September 30, 2029'' for ''through September 30, 2027'' in heading and ''2029,'' for ''2027'' in two places in text.

Subsec. (mm). Pub. L. 117–328, §5123(b)(2), added subsec. (mm) and struck out former subsec. (mm) which related to directory physician or provider described.

Subsec. (nn)(3). Pub. L. 117–328, §5121(a)(2), substituted ''(31)'' for ''(30)''.

Subsec. (tt). Pub. L. 117–328, §5131(b), added subsec. (tt).

2021—Subsec. (a)(10). Pub. L. 117–2, §9811(a)(2)(F), inserted before semicolon at end of concluding provisions '', and (XIX) medical assistance shall be made available during the period described in section 1396d(a)(4)(E) of this title for vaccines described in such section and the administration of such vaccines, for any individual who is eligible for and receiving medical assistance under the State plan or under a waiver of such plan (other than an individual who is eligible for medical assistance consisting only of payment of premiums pursuant to subparagraph (E) or (F) or section 1396u–3 of this title), notwithstanding any provision of this subchapter or waiver under section 1315 of this title impacting such individual's eligibility for medical assistance under such plan or waiver to coverage for a limited type of benefits and services that would not otherwise include coverage of a COVID–19 vaccine and its administration''.

Pub. L. 117–2, §9811(a)(2)(E), in concluding provisions, substituted '', any service described in section 1396*o*(a)(2)(G) of this title that is furnished during any such portion, any vaccine described in section 1396d(a)(4)(E) of this title (and the administration of such vaccine) that is furnished during any such portion, and testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan)'' for ''and any visit described in section 1396*o*(a)(2)(G) of this title that is furnished during any such portion''.

Pub. L. 117–2, §9811(a)(2)(D), in concluding provisions, inserted ''and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section'' after ''family planning setting''.

Pub. L. 117–2, §9811(a)(2)(C), in concluding provisions, inserted ''and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section'' after ''described in subsection (k)(1)''.

Pub. L. 117–2, §9811(a)(2)(B), in concluding provisions, inserted ''and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section'' after ''(described in subsection (z)(2))''.

Pub. L. 117–2, §9811(a)(2)(A), in concluding provisions, substituted '', medical assistance for services related to other conditions which may complicate pregnancy, and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (VIII)'' for ''and to other conditions which may complicate pregnancy, (VIII)''.

Subsec. (e)(16). Pub. L. 117–2, § 9812(a), added par. (16).

2020—Subsec. (a)(4)(A). Pub. L. 116–260, § 209(a)(1), substituted ''including provision for utilization'' for ''and including provision for utilization'' and inserted '', and, subject to section 1396b(i) of this title, including a specification that the single State agency described in paragraph (5) will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the methods that such agency will use to ensure such transportation'' after ''supervision of administration of the plan''.

Subsec. (a)(10). Pub. L. 116–127, § 6004(a)(3)(A)(ii), in concluding provisions, substituted '', (XVII)'' for ''and (XVII)'' and inserted before semicolon at end '', and (XVIII) the medical assistance made available to an uninsured individual (as defined in subsection (ss)) who is eligible for medical assistance only because of subparagraph (A)(ii)(XXIII) shall be limited to medical assistance for any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product) and any visit described in section 1396*o*(a)(2)(G) of this title that is furnished during any such portion''.

Subsec. (a)(10)(A). Pub. L. 116–260, § 210(b), substituted ''(29), and (30)'' for ''and (29)'' in introductory provisions.

Subsec. (a)(10)(A)(ii)(XXIII). Pub. L. 116–127, § 6004(a)(3)(A)(i), added subcl. (XXIII).

Subsec. (a)(10)(E)(iii), (iv). Pub. L. 116–260, § 402(f)(2), inserted ''(including such individuals enrolled under section 1395*o*(b) of this title)'' after ''section 1396d(p)(1) of this title''.

Subsec. (a)(55). Pub. L. 116–127, § 6004(a)(3)(B), substituted ''(a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XXIII)'' for ''or (a)(10)(A)(ii)(IX)'' in introductory provisions.

Subsec. (a)(87). Pub. L. 116–260, § 209(b)(4)(A), added par. (87).

Subsec. (h). Pub. L. 116–136, § 3715, designated existing provisions as par. (1), inserted '', home and community-based services provided under subsection (c), (d), or (i) of section 1396n of this title or under a waiver or demonstration project under section 1315 of this title, self-directed personal assistance services provided pursuant to a written plan of care under section 1396n(j) of this title, and home and community-based attendant services and supports under section 1396n(k) of this title'' before period at end, and added par. (2).

Subsec. (ss). Pub. L. 116–127, § 6004(a)(3)(C), added subsec. (ss).

Subsec. (ss)(1). Pub. L. 116–136, § 3716(1), inserted ''(excluding subclause (VIII) of such subsection if the individual is a resident of a State which does not furnish medical assistance to individuals described in such subclause)'' after ''subsection (a)(10)(A)(i)''.

Subsec. (ss)(2). Pub. L. 116–136, § 3716(2), inserted before period at end '', except that individuals who are eligible for medical assistance under subsection (a)(10)(A)(ii)(XII), subsection (a)(10)(A)(ii)(XVIII), subsection (a)(10)(A)(ii)(XXI), or subsection (a)(10)(C) (but only to the extent such an individual is considered to not have minimum essential coverage under section 5000A(f)(1) of the Internal Revenue Code of 1986), or who are described in subsection (*l*)(1)(A) and are eligible for medical assistance only because of subsection (a)(10)(A)(i)(IV) or (a)(10)(A)(ii)(IX) and whose eligibility for such assistance is limited by the State under clause (VII) in the matter following subsection (a)(10)(G), shall not be treated as enrolled in a Federal health care program for purposes of this paragraph''.

2019—Subsec. (a)(25)(F)(i). Pub. L. 116–16, § 7(a), amended Pub. L. 113–67, § 202(a)(2). See 2013 Amendment note below.

Subsec. (j). Pub. L. 116–94, § 202(e)(2), substituted '', the requirement'' for ''or the requirement'' and inserted '', or the requirement under subsection (qq)(1) (relating to data reporting)'' before period at end.

Subsec. (qq). Pub. L. 116–94, § 202(e)(1), added subsec. (qq).

Subsec. (rr). Pub. L. 116–94, § 202(f)(4), added subsec. (rr).

2018—Subsec. (a)(10)(A). Pub. L. 115–271, § 1006(b)(1), substituted ''(28), and (29)'' for ''and (28)'' in introductory provisions.

Subsec. (a)(10)(A)(i)(IX)(bb). Pub. L. 115–271, § 1002(a)(1)(A), substituted ''are not described in and are not enrolled under'' for ''are not described in or enrolled under''.

Subsec. (a)(10)(A)(i)(IX)(cc). Pub. L. 115–271, § 1002(a)(1)(B), substituted ''responsibility of a State'' for ''responsibility of the State''.

Subsec. (a)(10)(A)(i)(IX)(dd). Pub. L. 115–271, § 1002(a)(1)(C), substituted ''a State plan under this subchapter or under a waiver of such a'' for ''the State plan under this subchapter or under a waiver of the''.

Subsec. (a)(17). Pub. L. 115–123, § 53103(a)(1), substituted ''(e)(14), (e)(15)'' for ''(e)(14), (e)(14)''.

Subsec. (a)(25)(B). Pub. L. 115–123, § 53102(b)(1), repealed Pub. L. 113–67, § 202(b)(1)(A), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

Subsec. (a)(25)(E). Pub. L. 115–123, § 53102(a)(1), struck out ''prenatal or'' after ''in the case of'' in introductory provisions.

Subsec. (a)(25)(H). Pub. L. 115–123, § 53102(b)(1), repealed Pub. L. 113–67, § 202(b)(1)(B), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

Subsec. (a)(25)(I)(i). Pub. L. 115–123, § 53102(d)(2), substituted ''medical assistance under a State plan (or under a waiver of the plan) under this subchapter and child health assistance under subchapter XXI'' for ''medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI)''.

Subsec. (a)(84). Pub. L. 115–271, § 1001(a)(1), added par. (84).

Subsec. (a)(85). Pub. L. 115–271, § 1004(a)(1), added par. (85).

Subsec. (a)(86). Pub. L. 115–271, § 1007(a), added par. (86).

Subsec. (e)(13)(I). Pub. L. 115–123, § 50101(e), substituted ''2027'' for ''2023''.

Pub. L. 115–120, § 3002(e), substituted ''2023'' for ''2017''.

Subsec. (e)(14). Pub. L. 115–120, § 3004(c)(2), redesignated par. (14), relating to exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition, as (15).

Subsec. (e)(14)(J). Pub. L. 115–120, § 3004(c)(1), which directed addition of subpar. (J) to ''first'' par. (14), relating to income determined using modified adjusted gross income, was executed by making the addition to what had been the second par. (14) to reflect the probable intent of Congress.

Subsec. (e)(14)(K). Pub. L. 115–123, § 53103(a)(2), added subpar. (K).

Subsec. (e)(15). Pub. L. 115–120, § 3004(c)(2), redesignated first par. (14), relating to exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition, as (15). As redesignated, par. (15) was moved to appear after par. (14), to reflect the probable intent of Congress.

Subsec. (gg)(2). Pub. L. 115–123, § 50101(f)(2)(B), which directed amendment of par. (2) by substituting ''2027'' for ''2023,'' wherever appearing, was executed by substituting ''2027 (but during'' for ''2023 (but during'' and ''2027 only with'' for ''2023, only with'' to reflect the probable intent of Congress.

Pub. L. 115–123, § 50101(f)(2)(A), substituted ''through september 30, 2027'' for ''through September 30, 2023'' in heading.

Pub. L. 115–120, § 3002(f)(2), substituted ''through September 30, 2023'' for ''until October 1, 2019'' in heading and ''September 30, 2023 (but during the period that begins on October 1, 2019, and ends on September 30, 2023, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as de-

fined in section 1397jj(c)(5) of this title) applicable to a family of the size involved)'' for ''September 30, 2019,'' in text.

Subsec. (nn). Pub. L. 115–271, §1001(a)(2), added subsec. (nn).

Subsec. (*oo*). Pub. L. 115–271, §1004(a)(2), added subsec. (*oo*).

Subsec. (pp). Pub. L. 115–271, §1007(b), added subsec. (pp).

2016—Subsec. (a)(39). Pub. L. 114–255, §5005(c)(2), substituted ''subchapter XVIII, any other State plan under this subchapter (or waiver of the plan), or any State child health plan under subchapter XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act'' for ''subchapter XVIII or any other State plan under this subchapter''.

Subsec. (a)(41). Pub. L. 114–255, §5005(a)(6), substituted ''provide, in accordance with subsection (kk)(8) (as applicable), that whenever'' for ''provide that whenever''.

Subsec. (a)(78). Pub. L. 114–255, §5005(b)(1), added par. (78).

Subsec. (a)(82). Pub. L. 114–198 added par. (82).

Subsec. (a)(83). Pub. L. 114–255, §5006(a), added par. (83).

Subsec. (kk)(1), (2). Pub. L. 114–255, §17004(b)(2)(B)(i), (ii), made technical amendment to reference in original act which appears in text as reference to section 1395cc of this title.

Subsec. (kk)(3). Pub. L. 114–255, §17004(b)(2)(B)(iii), made technical amendment to reference in original act which appears in text as reference to section 1395cc of this title and substituted ''(j)(5)'' for ''(j)(4)''.

Subsec. (kk)(4)(A)(i). Pub. L. 114–255, §17004(b)(2)(B)(iv), made technical amendment to reference in original act which appears in text as reference to section 1395cc of this title and substituted ''(j)(7)'' for ''(j)(6)''.

Subsec. (kk)(4)(A)(ii). Pub. L. 114–255, §17004(b)(1)(B), amended cl. (ii) generally. Prior to amendment, text read as follows: ''A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.''

Subsec. (kk)(4)(A)(iii). Pub. L. 114–255, §17004(b)(1)(C), added cl. (iii).

Subsec. (kk)(8), (9). Pub. L. 114–255, §5005(a)(1), added par. (8) and redesignated former par. (8) as (9).

Subsec. (*ll*). Pub. L. 114–255, §5005(a)(3), added subsec. (*ll*).

Subsec. (mm). Pub. L. 114–255, §5006(b), added subsec. (mm).

2015—Subsec. (a)(10)(E)(iv). Pub. L. 114–10, §211(a), struck out ''(but only for premiums payable with respect to months during the period beginning with January 1998, and ending with March 2015)'' after ''available''.

Subsec. (a)(17). Pub. L. 114–63, §2, repealed Pub. L. 111–255, §3(e). See 2010 Amendment note and Effective Date of 2015 Amendment note below.

Subsec. (e)(1). Pub. L. 114–10, §212(b), amended par. (1) generally. Prior to amendment, par. (1) read as follows:

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

''(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter during the period beginning on April 1, 1990, and ending on March 31, 2015. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV of this chapter and have earned income, see section 1396r–6 of this title.''

Subsec. (e)(13)(I). Pub. L. 114–10, §302, substituted ''2017'' for ''2015''.

Subsec. (e)(14). Pub. L. 114–63, §2, repealed Pub. L. 111–255, §3(e). See 2010 Amendment note and Effective Date of 2015 Amendment note below.

2014—Subsec. (a)(10)(E)(iv). Pub. L. 113–93, §201(a), substituted ''March 2015'' for ''March 2014''.

Subsec. (e)(1)(B). Pub. L. 113–93, §202, substituted ''March 31, 2015'' for ''March 31, 2014''.

Subsec. (e)(13)(I). Pub. L. 113–93, §203, substituted ''September 30, 2015'' for ''September 30, 2014''.

2013—Subsec. (a)(10)(E)(iv). Pub. L. 113–67, §1201(a), substituted ''March 2014'' for ''December 2013''.

Pub. L. 112–240, §621(a), substituted ''2013'' for ''2012''.

Subsec. (a)(25)(B). Pub. L. 113–67, §202(b)(1)(A), which directed striking out ''to the extent of such legal liability'' before semicolon at end, was repealed by Pub. L. 115–123, §53102(b)(1).

Subsec. (a)(25)(E)(i). Pub. L. 113–67, §202(a)(1), which directed amendment of cl. (i) by inserting before semicolon at end '', except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services'', was executed by making the insertion before ''; and'' to reflect the probable intent of Congress.

Subsec. (a)(25)(F)(i). Pub. L. 113–67, §202(a)(2), as amended by Pub. L. 116–16, §7(a), substituted ''100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.'' for ''30 days after such services are furnished''.

Subsec. (a)(25)(H). Pub. L. 113–67, §202(b)(1)(B), which directed substituting ''any payments by such third party'' for ''payment by any other party for such health care items or services'', was repealed by Pub. L. 115–123, §53102(b)(1).

Subsec. (a)(81) to (83). Pub. L. 112–240, §642(b)(2), redesignated par. (83) as (81) and struck out former pars. (81) and (82) which required States to comply with regulations relating to payor rules with respect to beneficiaries under both the Medicaid and CLASS programs and to take certain actions relating to workers who provide personal care services to individuals under the CLASS program.

Subsec. (e)(1)(B). Pub. L. 113–67, §1202, substituted ''March 31, 2014'' for ''December 31, 2013''.

Pub. L. 112–240, §622, substituted ''2013'' for ''2012''.

Subsec. (e)(13)(I). Pub. L. 112–240, §623, substituted ''2014'' for ''2013''.

2012—Subsec. (a)(10)(E)(iv). Pub. L. 112–96, §3101(a), substituted ''December 2012'' for ''February 2012''.

Subsec. (e)(1)(B). Pub. L. 112–96, §3102, substituted ''December 31'' for ''February 29''.

2011—Subsec. (a)(10)(E)(iv). Pub. L. 112–78, §310(a), substituted ''February 2012'' for ''December 2011''.

Subsec. (e)(1)(B). Pub. L. 112–78, §311, substituted ''February 29, 2012'' for ''December 31, 2011''.

2010—Subsec. (a)(7). Pub. L. 111–296, §103(c)(1), amended par. (7) generally. Prior to amendment, par. (7) read as follows: ''provide safeguards which restrict the use

or disclosure of information concerning applicants and recipients to purposes directly connected with—

''(A) the administration of the plan; and

''(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;''.

Subsec. (a)(9)(D). Pub. L. 111–148, § 6103(d)(2), added subpar. (D).

Subsec. (a)(10). Pub. L. 111–309, § 205(f)(1)(A), in concluding provisions, struck out ''and'' before ''(XVI) the medical'' and substituted ''(XVII) if'' for ''(XVI) if''.

Pub. L. 111–148, § 10201(a)(2), which directed amendment of par. (10) in the matter following subparagraph (G) by substituting ''(XV)'' for ''and (XV)'' and inserting ''and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)'' before the semicolon, was executed by making the insertion only, to reflect the probable intent of Congress. The substitution could not be executed because ''and (XV)'' did not appear after amendment by Pub. L. 111–148, § 2303(a)(3). See below.

Pub. L. 111–148, § 2303(a)(3), in concluding provisions, substituted ''(XV)'' for ''and (XV)'' and inserted before semicolon at end '', and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting''.

Pub. L. 111–148, § 2001(a)(5)(A), in concluding provisions, substituted ''(XIV)'' for ''and (XIV)'' and inserted before semicolon at end ''and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)''.

Subsec. (a)(10)(A). Pub. L. 111–148, § 2301(b), substituted '', (21), and (28)'' for ''and (21)'' in introductory provisions.

Subsec. (a)(10)(A)(i)(VIII). Pub. L. 111–148, § 2001(a)(1), added subcl. (VIII).

Subsec. (a)(10)(A)(i)(IX). Pub. L. 111–148, § 10201(a)(1), amended subcl. (IX) generally. Prior to amendment, subcl. (IX) read as follows: ''who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;''.

Pub. L. 111–148, § 2004(a), added subcl. (IX).

Subsec. (a)(10)(A)(ii)(XX). Pub. L. 111–148, § 2001(e)(1)(A), added subcl. (XX).

Subsec. (a)(10)(A)(ii)(XXI). Pub. L. 111–148, § 2303(a)(1), added subcl. (XXI).

Subsec. (a)(10)(A)(ii)(XXII). Pub. L. 111–148, § 2402(d)(1), added subcl. (XXII).

Subsec. (a)(10)(E)(iv). Pub. L. 111–309, § 110(a), substituted ''December 2011'' for ''December 2010''.

Subsec. (a)(13)(C). Pub. L. 111–152, § 1202(a)(1)(A), added subpar. (C).

Subsec. (a)(17). Pub. L. 111–255, § 3(e), which directed the repeal of the amendment made by Pub. L. 111–255, § 3(c)(2), effective 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, § 2, effective as if included in Pub. L. 111–255.

Pub. L. 111–255, § 3(c)(2), inserted ''(e)(14),'' before ''(*l*)(3)''.

Pub. L. 111–148, § 2002(b), inserted ''(e)(14),'' before ''(*l*)(3)''.

Subsec. (a)(23). Pub. L. 111–309, § 205(f)(1)(B), which directed amendment by substituting ''(kk)'' for ''(ii)'', was executed by substituting ''(kk)(4)'' for ''(ii)(4)'', to reflect the probable intent of Congress.

Pub. L. 111–148, § 6401(b)(3), inserted before semicolon at end ''or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium''.

Subsec. (a)(39). Pub. L. 111–148, § 6501, inserted ''terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a–7(c)(3)(B) and 1320a–7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII or any other State plan under this subchapter,'' after ''1320a–7a of this title,''.

Subsec. (a)(42). Pub. L. 111–148, § 6411(a)(1), substituted ''provide that—'' for ''provide that'', inserted subpar. (A) designation before ''the records'' and ''and'' after semicolon at end, and added subpar. (B).

Subsec. (a)(47). Pub. L. 111–148, § 2202(a), substituted ''provide—'' for ''at the option of the State, provide'', inserted subpar. (A) designation and ''at the option of the State,'' before ''for making ambulatory'' and ''and'' after semicolon at end, and added subpar. (B).

Subsec. (a)(47)(A). Pub. L. 111–148, § 2303(b)(2)(A)(i), inserted before semicolon at end ''and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period in accordance with such section''.

Subsec. (a)(47)(B). Pub. L. 111–148, § 2303(b)(2)(A)(ii), substituted ''1396r–1b, or 1396r–1c of this title'' for ''or 1396r–1b of this title''.

Subsec. (a)(74). Pub. L. 111–148, § 4302(b)(1)(A)(i), which directed amendment of ''paragraph 4)'' by striking ''and'' at the end, was executed to par. (74) to reflect the probable intent of Congress.

Pub. L. 111–148, § 2001(b)(1), added par. (74).

Subsec. (a)(75). Pub. L. 111–148, § 4302(b)(1)(A)(ii), substituted ''; and'' for period at end.

Pub. L. 111–148, § 2001(d)(1), added par. (75).

Subsec. (a)(76). Pub. L. 111–148, § 4302(b)(1)(A)(iii), added par. (76).

Subsec. (a)(77). Pub. L. 111–309, § 205(f)(1)(C), substituted ''(kk)'' for ''(ii)''.

Pub. L. 111–148, § 6401(b)(1)(A), added par. (77).

Subsec. (a)(78). Pub. L. 111–309, § 205(a), struck out par. (78). Text read as follows: ''provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments (as defined by the Secretary) under this subchapter during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this subchapter during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this subchapter or whose participation is terminated under this subchapter during such period;''.

Pub. L. 111–148, § 6502, added par. (78).

Subsec. (a)(79). Pub. L. 111–148, § 6503, added par. (79).

Subsec. (a)(80). Pub. L. 111–148, § 6505, added par. (80).

Subsec. (a)(81). Pub. L. 111–148, § 8002(a)(2), added par. (81).

Subsec. (a)(82). Pub. L. 111–148, § 8002(b), added par. (82).

Subsec. (a)(83). Pub. L. 111–148, § 3021(b), added par. (83).

Subsec. (e)(1)(B). Pub. L. 111–309, § 111, substituted ''December 31, 2011'' for ''December 31, 2010''.

Subsec. (e)(13)(F)(ii). Pub. L. 111–148, § 2901(c), inserted ''and indian tribes and tribal organizations'' after ''agencies'' in heading and added subcl. (IV).

Subsec. (e)(14). Pub. L. 111–255, § 3(e), which directed the repeal of the amendment made by Pub. L. 111–255, § 3(c)(1), effective 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, § 2, effective as if included in Pub. L. 111–255.

Pub. L. 111–255, §3(c)(1), added par. (14) related to exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition.

Pub. L. 111–152, §1004(b)(1)(A), substituted ''modified adjusted gross income'' for ''modified gross income'' wherever appearing in headings and text.

Pub. L. 111–148, §2002(a), added par. (14) related to income determined using modified gross income.

Subsec. (e)(14)(B). Pub. L. 111–152, §1004(e)(1), substituted ''Subject to subparagraph (I), no type'' for ''No type''.

Subsec. (e)(14)(I). Pub. L. 111–152, §1004(e)(2), added subpar. (I).

Subsec. (k). Pub. L. 111–148, §2001(a)(4)(A), added pars. (2) and (3).

Pub. L. 111–148, §2001(a)(2)(A), added subsec. (k).

Subsec. (k)(2). Pub. L. 111–148, §10201(b), substituted ''April 1, 2010'' for ''January 1, 2011''.

Subsec. (*l*)(2)(C). Pub. L. 111–309, §205(b), substituted ''100 percent (or, beginning January 1, 2014, 133 percent)'' for ''133 percent''.

Pub. L. 111–148, §2001(a)(5)(B), substituted ''133'' for ''100''.

Subsec. (gg). Pub. L. 111–148, §2001(b)(2), added subsec. (gg).

Subsec. (gg)(4)(A). Pub. L. 111–152, §1004(b)(1)(B), substituted ''modified adjusted gross income'' for ''modified gross income'' in heading.

Subsec. (hh). Pub. L. 111–148, §2001(e)(1)(B), added subsec. (hh).

Subsec. (ii). Pub. L. 111–309, §205(f)(1)(E), redesignated subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements as (kk).

Pub. L. 111–148, §6401(b)(1)(B), added subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements.

Pub. L. 111–148, §2303(a)(2), added subsec. (ii) relating to State eligibility option for family planning services.

Subsec. (ii)(2). Pub. L. 111–309, §205(f)(1)(D), substituted ''(XVI)'' for ''(XV)''.

Subsec. (jj). Pub. L. 111–152, §1202(a)(1)(B), added subsec. (jj).

Subsec. (kk). Pub. L. 111–309, §205(f)(1)(E), redesignated subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements as (kk).

2009—Subsec. (a)(10)(E)(iv). Pub. L. 111–5, §5005(a), substituted ''December 2010'' for ''December 2009''.

Subsec. (a)(25)(I)(i). Pub. L. 111–3, §203(d)(3), inserted ''(and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title)'' after ''with respect to individuals who are eligible'' and ''under this subchapter (and, at State option, child health assistance under subchapter XXI)'' after ''the State plan''.

Subsec. (a)(43)(D)(iii). Pub. L. 111–3, §501(e)(1), inserted ''and other information relating to the provision of dental services to such children described in section 1397hh(e) of this title'' after ''receiving dental services,''.

Subsec. (a)(46). Pub. L. 111–3, §211(a)(1)(A)(i), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(72). Pub. L. 111–3, §501(d)(1), added par. (72).

Subsec. (a)(73). Pub. L. 111–5, §5006(e)(2)(A), added par. (73).

Subsec. (e)(1)(B). Pub. L. 111–5, §5004(a)(1), substituted ''December 31, 2010'' for ''September 30, 2003''.

Subsec. (e)(4). Pub. L. 111–3, §211(b)(3)(B), inserted at end ''Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1396b(v) of this title, the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.''

Pub. L. 111–3, §113(b)(1), struck out ''so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance'' before period at end of first sentence.

Subsec. (e)(13). Pub. L. 111–3, §203(a)(1), added par. (13).

Subsec. (dd). Pub. L. 111–3, §203(c), added subsec. (dd).

Subsec. (ee). Pub. L. 111–3, §211(a)(1)(A)(ii), added subsec. (ee).

Subsec. (ff). Pub. L. 111–5, §5006(b)(1), added subsec. (ff).

2008—Subsec. (a)(10)(E)(iv). Pub. L. 110–275 substituted ''December 2009'' for ''June 2008''.

Subsec. (a)(71). Pub. L. 110–252 added par. (71).

2007—Subsec. (a)(10)(E)(iv). Pub. L. 110–173 substituted ''June 2008'' for ''December 2007''.

Pub. L. 110–90 substituted ''December 2007'' for ''September 2007''.

2006—Subsec. (a)(10)(A)(i)(II). Pub. L. 109–171, §6065(a), inserted ''(aa)'' after ''(II)'', substituted ''and'' for '') and'' after ''P.L. 104–193)'', substituted ''section), (bb) who are'' for ''section or who are'', and inserted before comma at end '', or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase 'the first day of the month following' ''.

Subsec. (a)(10)(A)(ii)(XIX). Pub. L. 109–171, §6062(a)(1)(A), added subcl. (XIX).

Subsec. (a)(25)(A). Pub. L. 109–171, §6035(a)(1), in introductory provisions, inserted '', self-insured plans'' after ''health insurers'' and substituted ''managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'' for ''and health maintenance organizations''.

Subsec. (a)(25)(G). Pub. L. 109–171, §6035(a)(2), inserted ''a self-insured plan,'' before ''a service benefit plan'' and substituted ''a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'' for ''and a health maintenance organization''.

Subsec. (a)(25)(I). Pub. L. 109–171, §6035(b), added subpar. (I).

Subsec. (a)(68). Pub. L. 109–171, §6032(a), added par. (68).

Subsec. (a)(69). Pub. L. 109–171, §6034(b), as amended by Pub. L. 109–432, added par. (69).

Subsec. (a)(70). Pub. L. 109–171, §6083(a), added par. (70).

Subsec. (cc). Pub. L. 109–171, §6062(a)(1)(B), added subsec. (cc).

Subsec. (cc)(2). Pub. L. 109–171, §6062(a)(2), added par. (2).

2005—Subsec. (a)(10)(E)(iv). Pub. L. 109–91 substituted ''September 2007'' for ''September 2005''.

2004—Subsec. (a)(7). Pub. L. 108–265 designated part of existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10)(E)(iv). Pub. L. 108–448 substituted ''2005'' for ''2004''.

2003—Subsec. (a)(10)(E)(iv). Pub. L. 108–173, §103(f)(1), substituted ''ending with September 2004'' for ''ending with March 2004''.

Pub. L. 108–89 substituted ''March 2004'' for ''December 2002'', redesignated introductory provisions and subcl. (I) as cl. (iv), substituted semicolon for '', and'' after ''State plan'', and struck out subcl. (II) which read as follows: ''for the portion of medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if '135 percent' and '175 percent' were substituted for '120 percent' and '135 percent' respectively;''.

Subsec. (a)(66). Pub. L. 108–173, §103(a)(1), added par. (66).

Subsec. (a)(67). Pub. L. 108–173, §236(b)(1), added par. (67).

Subsec. (e)(1)(B). Pub. L. 108–40 substituted ''2003'' for ''2002''.

2002—Subsec. (a)(15). Pub. L. 107–121, §2(b)(2), substituted ''subsection (bb)'' for ''subsection (aa)''.

Subsec. (aa). Pub. L. 107–121, §2(b)(1), redesignated subsec. (aa) relating to payment for services provided by federally-qualified health centers and rural health clinics as subsec. (bb).

Subsec. (aa)(4). Pub. L. 107–121, §2(a), inserted '', but applied without regard to paragraph (1)(F) of such section'' before period at end.

Subsec. (bb). Pub. L. 107–121, §2(b)(1), redesignated subsec. (aa) relating to payment for services provided by federally-qualified health centers and rural health clinics as subsec. (bb).

2000—Subsec. (a)(10). Pub. L. 106–354, §2(a)(3), in concluding provisions, substituted ''(XIII)'' for ''and (XIII)'' and inserted before semicolon at end '', and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer''.

Subsec. (a)(10)(A)(ii)(XVIII). Pub. L. 106–354, §2(a)(1), added subcl. (XVIII).

Subsec. (a)(13)(A)(iv). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(A)], inserted ''and'' at end.

Subsec. (a)(13)(B). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(B)], struck out ''and'' at end.

Subsec. (a)(13)(C). Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)], repealed Pub. L. 105–33, §4712(c)(1). See 1997 Amendment note below.

Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(C)], struck out subpar. (C) which read as follows: ''(C)(i) for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent (or 95 percent for services furnished during fiscal year 2000, fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004) of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1395*l*(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 1395*l*(a)(3) of this title and (ii) in carrying out clause (i) in the case of services furnished by a Federally-qualified health center or a rural health clinic pursuant to a contract between the center and an organization under section 1396b(m) of this title, for payment to the center or clinic at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract;''.

Subsec. (a)(15). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(2)], added par. (15).

Subsec. (a)(47). Pub. L. 106–354, §2(b)(2)(A), inserted before semicolon at end ''and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period in accordance with such section''.

Subsec. (e)(1)(B). Pub. L. 106–554, §1(a)(6) [title VII, §707(b)], substituted ''2002'' for ''2001''.

Subsec. (aa). Pub. L. 106–554, §1(a)(6) [title VII, §702(b)], added subsec. (aa) relating to payment for services provided by Federally-qualified health centers and rural health clinics.

Pub. L. 106–354, §2(a)(2), added subsec. (aa) relating to certain breast or cervical cancer patients.

1999—Subsec. (a)(10)(A)(ii)(XIV). Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(1)], substituted ''1396d(u)(2)(B) of this title'' for ''1396d(u)(2)(C) of this title''.

Subsec. (a)(10)(A)(ii)(XV). Pub. L. 106–169, §121(c)(4)(A), redesignated subcl. (XV), related to individuals who are independent foster care adolescents, as (XVII).

Pub. L. 106–169, §121(a)(1)(C), added subcl. (XV), related to individuals who are independent foster care adolescents.

Pub. L. 106–169, §121(a)(1)(A), which directed striking out of ''or'' at end of subcl. (XIII), was executed by amending subcl. (XV), related to individuals who would be considered to be receiving supplemental security income, etc. See Construction of 1999 Amendment note below.

Pub. L. 106–170, §201(a)(1), added subcl. (XV), related to individuals who would be considered to be receiving supplemental security income, etc.

Subsec. (a)(10)(A)(ii)(XVI). Pub. L. 106–169, §121(a)(1)(B), which directed insertion of ''or'' at end of subcl. (XIV), was executed to subcl. (XVI). See Construction of 1999 Amendment note below.

Pub. L. 106–170, §201(a)(2)(A), added subcl. (XVI).

Subsec. (a)(10)(A)(ii)(XVII). Pub. L. 106–169, §121(c)(4), redesignated subcl. (XV), related to individuals who are independent foster care adolescents, as (XVII) and substituted ''section 1396d(w)(1)'' for ''section 1396d(v)(1)''.

Subsec. (a)(10)(G). Pub. L. 106–169, §206(b), substituted ''subsections (c) and (e) of section 1382b'' for ''section 1382b(e)''.

Pub. L. 106–169, §205(c), added subpar. (G).

Subsec. (a)(13)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §603(a)(1)], substituted ''fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004'' for ''90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003''.

Subsec. (a)(30)(A). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(A)], inserted ''and'' at end.

Subsec. (a)(30)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(B)], struck out ''and'' at end.

Subsec. (a)(30)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(C)], struck out subpar. (C) which read as follows: ''use a utilization and quality control peer review organization (under part B of subchapter XI of this chapter), an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1396b(m) of this title, with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;''.

Subsec. (a)(60). Pub. L. 106–113, §1000(a)(6) [title VI, §608(y)(2)], made technical amendment to reference in original act which appears in text as reference to section 1396g-1 of this title.

Subsec. (a)(64). Pub. L. 106–113, §1000(a)(6) [title VI, §608(a)], inserted ''and'' at end.

Subsec. (d). Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(2)(A)], struck out ''(including quality review functions described in subsection (a)(30)(C) of this section)'' after ''medical or utilization review functions''.

Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(1)], struck out ''for the performance of the quality review functions described in subsection (a)(30)(C) of this section,'' before ''or a utilization and quality control peer review organization''.

Subsec. (j). Pub. L. 106–113, §1000(a)(6) [title VI, §608(b)], substituted ''of'' for ''of of'' after ''numbered paragraph''.

Subsec. (*l*)(1)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(1)], substituted ''children'' for ''children children''.

Subsec. (*l*)(3). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(2)], struck out first comma after ''(a)(10)(A)(i)(VII)'' in introductory provisions.

Subsec. (*l*)(4)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(3)], inserted comma after ''(a)(10)(A)(i)(IV)''.

Subsec. (v). Pub. L. 106–113, §1000(a)(6) [title VI, §608(d)], struck out par. (1) designation before ''A State plan may provide''.

1997—Subsec. (a). Pub. L. 105–33, § 4454(b)(1), in second sentence of flush concluding provisions, substituted ''to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).'' for ''to a Christian Science sanatorium operated, or listed and certified, by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.''

Subsec. (a)(4)(C), (D). Pub. L. 105–33, § 4724(c)(1), substituted ''(C)'' for ''and (C)'', ''local officer, employee, or independent contractor'' for ''local officer or employee'', and ''such an officer, employee, or contractor'' for ''such an officer or employee'' in two places and added subpar. (D).

Subsec. (a)(9)(C). Pub. L. 105–33, § 4106(c), substituted ''paragraphs (16) and (17)'' for ''paragraphs (15) and (16)''.

Subsec. (a)(10)(A)(i)(II). Pub. L. 105–33, § 4913(a), inserted ''(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section'' after ''subchapter XVI''.

Subsec. (a)(10)(A)(ii)(XIII). Pub. L. 105–33, § 4733, added subcl. (XIII).

Subsec. (a)(10)(A)(ii)(XIV). Pub. L. 105–33, § 4911(b), added subcl. (XIV).

Subsec. (a)(10)(E)(iv). Pub. L. 105–33, § 4732(a), added cl. (iv).

Subsec. (a)(13)(A). Pub. L. 105–33, § 4711(a)(1), added subpar. (A) and struck out former subpar. (A) which related to payment of hospital services, nursing facility services, and services in intermediate care facilities for mentally retarded by use of rates which account for various specified costs.

Subsec. (a)(13)(B). Pub. L. 105–33, § 4711(a)(1)–(3), redesignated subpar. (D) as (B), inserted ''and'' at end, and struck out former subpar. (B) which read as follows: ''that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title;''.

Subsec. (a)(13)(C). Pub. L. 105–33, § 4712(c)(1), which directed the repeal of subsec. (a)(13)(C), was repealed by Pub. L. 106–554, § 1(a)(6) [title VII, § 702(c)(1)]. See 2000 Amendment note above and Effective Date of 1997 Amendment note below.

Pub. L. 105–33, § 4712(b)(1), designated existing provisions as cl. (i) and added cl. (ii).

Pub. L. 105–33, § 4712(a), inserted ''(or 95 percent for services furnished during fiscal year 2000, 90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003)'' after ''100 percent''.

Pub. L. 105–33, § 4711(a)(1), (2), (4), redesignated subpar. (E) as (C), struck out ''and'' at end, and struck out former subpar. (C) which read as follows: ''that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

''(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

''(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);''.

Subsec. (a)(13)(D), (E). Pub. L. 105–33, § 4711(a)(2), redesignated subpars. (D) and (E) as (B) and (C), respectively.

Subsec. (a)(13)(F). Pub. L. 105–33, § 4711(a)(5), struck out subpar. (F) which read as follows: ''for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;''.

Subsec. (a)(23). Pub. L. 105–33, § 4724(d), struck out ''except as provided in subsection (g) and in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam,'' after ''(23)'' and inserted before semicolon at end '', except as provided in subsection (g) and in section 1396n of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan''.

Subsec. (a)(23)(B). Pub. L. 105–33, § 4701(d)(1), substituted '', in section 1396n of this title, and in section 1396u–2(a) of this title'' for ''and in section 1396n of this title''.

Pub. L. 105–33, § 4701(b)(2)(A)(i), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (a)(25)(A)(ii). Pub. L. 105–33, § 4753(b), substituted ''be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;'' for the dash that followed ''which plan shall'' and struck out subcls. (I) and (II) which read as follows:

''(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1396b(r) of this title, and

''(II) be subject to the provisions of section 1396b(r)(4) of this title relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;''.

Subsec. (a)(25)(G) to (I). Pub. L. 105–33, § 4741(a), redesignated subpars. (H) and (I) as (G) and (H), respectively, and struck out former subpar. (G) which read as follows: ''that the State plan shall meet the requirements of section 1396e of this title (relating to enrollment of individuals under group health plans in certain cases);''.

Subsec. (a)(26). Pub. L. 105–33, § 4751(a), substituted ''provide, with respect to each patient'' for ''provide—

''(A) with respect to each patient''

and struck out subpars. (B) and (C) which read as follows:

''(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

''(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;''.

Subsec. (a)(31). Pub. L. 105–33, § 4751(b), substituted ''provide, with respect to each patient'' for ''provide—

''(A) with respect to each patient''
and struck out subpars. (B) and (C) which read as follows:

''(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

''(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;''.

Subsec. (a)(47). Pub. L. 105–33, § 4912(b)(1), inserted before semicolon at end ''and provide for making medical assistance for items and services described in subsection (a) of section 1396r–1a of this title available to children during a presumptive eligibility period in accordance with such section''.

Subsec. (a)(57). Pub. L. 105–33, § 4701(b)(2)(A)(ii), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (a)(63). Pub. L. 105–33, § 4724(g)(1)(A), struck out ''and'' at end.

Subsec. (a)(64). Pub. L. 105–33, § 4724(g)(1)(B), which directed the amendment of par. (64) by substituting ''; and'' for the period at end, could not be executed because there was no period at end.

Pub. L. 105–33, § 4724(f), added par. (64).

Subsec. (a)(65). Pub. L. 105–33, § 4724(g)(1)(C), added par. (65).

Subsec. (e)(2)(A). Pub. L. 105–33, § 4709(2), which directed the amendment of subsec. (e)(2) by inserting ''or by or through the case manager'' before period at end, was executed by making insertion before period at end of subpar. (A) to reflect the probable intent of Congress.

Pub. L. 105–33, § 4709(1), substituted ''who is enrolled with a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), with a primary care case manager (as defined in section 1396d(t) of this title),'' for ''who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title under a contract described in section 1396b(m)(2)(A) of this title''.

Subsec. (e)(12). Pub. L. 105–33, § 4731(a), added par. (12).

Subsec. (i)(1)(B). Pub. L. 105–33, § 4752(a), substituted ''establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide'' for ''provide''.

Subsec. (j). Pub. L. 105–33, § 4702(b)(2), substituted ''a numbered paragraph of'' for ''paragraphs (1) through (25)''.

Subsec. (*l*)(1)(D). Pub. L. 105–33, § 4731(b), inserted ''(or, at the option of a State, after any earlier date)'' after ''children born after September 30, 1983''.

Subsec. (n). Pub. L. 105–33, § 4714(a)(1), designated existing provisions as par. (1) and added pars. (2) and (3).

Subsec. (p)(2). Pub. L. 105–33, § 4701(b)(2)(A)(iii), substituted ''medicaid managed care organization'' for ''health maintenance organization'' in introductory provisions.

Subsec. (r)(1). Pub. L. 105–33, § 4715(a), designated existing provisions as subpar. (A), inserted '', the treatment described in subparagraph (B) shall apply,'' after ''under such a waiver'', substituted '', and'' for ''and,'' after ''Federal Republic of Germany'', and added subpar. (B).

Subsec. (w)(2)(E). Pub. L. 105–33, § 4701(b)(2)(A)(iv), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (w)(5). Pub. L. 105–12 added par. (5).

1996—Subsec. (a). Pub. L. 104–193, § 913, which directed substitution of ''The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.'' for ''The First Church of Christ, Scientist, Boston, Massachusetts'' in third sentence, was executed by making the substitution for ''the First Church of Christ, Scientist, Boston, Massachusetts'' in first undesignated closing par. to reflect the probable intent of Congress.

Subsec. (a)(25)(A)(i). Pub. L. 104–226 struck out ''including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b–14 of this title and any additional measures'' before ''as specified by the Secretary in regulations)''.

Subsec. (a)(59). Pub. L. 104–248 substituted ''subsection (x)'' for ''subsection (v)''.

Subsec. (a)(63). Pub. L. 104–193, § 114(b), added par. (63).

Subsec. (c). Pub. L. 104–193, § 114(d)(1), substituted ''if the State requires individuals described in subsection (*l*)(1) to apply for assistance under the State program funded under part A of subchapter IV as a condition of applying for or receiving medical assistance under this subchapter.'' for ''if—

''(1) the State has in effect, under its plan established under part A of subchapter IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

''(2) the State requires individuals described in subsection (*l*)(1) of this section to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this subchapter.''

Subsec. (e)(1)(B). Pub. L. 104–193, § 114(c), substituted ''2001'' for ''1998''.

Subsec. (j). Pub. L. 104–193, § 108(k), substituted ''1308(f)'' for ''1308(c)''.

1994—Subsec. (a)(10)(A)(ii)(XI). Pub. L. 103–296 substituted ''Commissioner of Social Security'' for ''Secretary''.

Subsec. (a)(11)(C), (53)(A). Pub. L. 103–448 substituted ''special supplemental nutrition program'' for ''special supplemental food program''.

1993—Subsec. (a)(10). Pub. L. 103–66, § 13603(c), in concluding provisions, substituted ''services, or hospitals, (XI)'' for ''services, or hospitals; and (XI)'' and ''other individuals, (XII)'' for ''other individuals, and (XI)'', and inserted '', and'' and subdiv. (XIII) before semicolon at end.

Subsec. (a)(10)(A)(ii)(XII). Pub. L. 103–66, § 13603(a), added subcl. (XII).

Subsec. (a)(10)(C)(iv). Pub. L. 103–66, § 13601(b)(1), substituted ''paragraphs numbered (1) through (24)'' for ''paragraphs numbered (1) through (21)''.

Subsec. (a)(11). Pub. L. 103–66, § 13631(f)(1)(A), (B), in subpar. (B), struck out ''effective July 1, 1969,'' after ''(B)'' and ''and'' before ''(ii)'' and substituted ''to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services'' for ''to him under section 1396b of this title'', and in subpar. (C), inserted '', including the provision of information and education on pediatric vaccinations and the delivery of immunization services,'' after ''operations under this subchapter''.

Subsec. (a)(18). Pub. L. 103–66, § 13611(d)(1)(A), substituted '', transfers of assets, and treatment of certain trusts'' for ''and transfers of assets''.

Subsec. (a)(25)(A). Pub. L. 103–66, § 13622(a), substituted ''insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations)'' for ''insurers)'' in introductory provisions.

Subsec. (a)(25)(A)(i). Pub. L. 103–66, § 13581(b)(2), substituted ''(including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b–14 of this title and any additional measures as specified'' for ''(as specified''.

Subsec. (a)(25)(H). Pub. L. 103–66, §13622(b), added subpar. (H).

Subsec. (a)(25)(I). Pub. L. 103–66, §13622(c), added subpar. (I).

Subsec. (a)(32)(D). Pub. L. 103–66, §13631(e)(1), added subpar. (D).

Subsec. (a)(43)(A). Pub. L. 103–66, §13631(f)(1)(C), inserted before comma at end ''and the need for age-appropriate immunizations against vaccine-preventable diseases''.

Subsec. (a)(51). Pub. L. 103–66, §13611(d)(1)(B), struck out ''(A)'' before ''meet the requirements'' and '', and (B) meet the requirement of section 1396p(c) of this title (relating to transfer of assets)'' after ''community spouses)''.

Subsec. (a)(54). Pub. L. 103–66, §13623(a)(1), which directed amendment of par. (54) by striking ''and'' at end, could not be executed because ''and'' did not appear at end subsequent to amendment by Pub. L. 103–66, §13602(c). See below.

Pub. L. 103–66, §13602(c), amended par. (54) generally. Prior to amendment, par. (54) read as follows:

''(A) provide that, any formulary or similar restriction (except as provided in section 1396r–8(d) of this title) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1396r–8(a) of this title, which are prescribed for a medically accepted indication (as defined in subsection 1396r–8(k)(6) of this title), and

''(B) comply with the reporting requirements of section 1396r–8(b)(2)(A) of this title and the requirements of subsections (d) and (g) of section 1396r–8 of this title; and''.

Subsec. (a)(55). Pub. L. 103–66, §13623(a)(3), redesignated par. (55) relating to providing for adjusted payments as (56).

Pub. L. 103–66, §13623(a)(2), amended par. (55) relating to providing for receipt and initial processing of applications by substituting semicolon for period at end of subpar. (B).

Subsec. (a)(56). Pub. L. 103–66, §13623(a)(3), redesignated par. (55) relating to providing for adjusted payments as (56), transferred such par. to appear after par. (55) relating to providing for receipt and initial processing of applications, and substituted semicolon for period at end.

Subsec. (a)(57). Pub. L. 103–66, §13623(a)(4), transferred par. (57) to appear after par. (56) as redesignated by Pub. L. 103–66, §13623(a)(3). See above.

Subsec. (a)(58). Pub. L. 103–66, §13623(a)(6), redesignated par. (58) relating to maintaining a list as (59).

Pub. L. 103–66, §13623(a)(5), amended par. (58) relating to providing that a State develop a written description of advance directive laws by substituting a semicolon for period at end.

Pub. L. 103–66, §13623(a)(4), transferred par. (58) relating to providing that a State develop a written description of advance directive laws to follow par. (57) which was transferred by Pub. L. 103–66, §13623(a)(4), to appear after par. (56), as redesignated by Pub. L. 103–66, §13623(a)(3). See above.

Subsec. (a)(59). Pub. L. 103–66, §13625(a)(1), struck out ''and'' at end.

Pub. L. 103–66, §13623(a)(6), redesignated par. (58), relating to maintaining a list, as (59), transferred such par. to appear after par. (58) relating to providing that a State develop a written description of advance directive laws, and substituted ''; and'' for period at end.

Subsec. (a)(60). Pub. L. 103–66, §13623(a)(7), added par. (60).

Subsec. (a)(61). Pub. L. 103–66, §13625(a), added par. (61).

Subsec. (a)(62). Pub. L. 103–66, §13631(a), added par. (62).

Subsec. (j). Pub. L. 103–66, §13601(b)(2), substituted ''paragraphs (1) through (25)'' for ''paragraphs (1) through (22)''.

Subsec. (k). Pub. L. 103–66, §13611(d)(1)(C), struck out subsec. (k) which read as follows:

''(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17) of this section, is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term 'grantor' means the individual referred to in paragraph (2).

''(2) For purposes of this subsection, a 'medicaid qualifying trust' is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

''(3) This subsection shall apply without regard to—

''(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this subchapter; or

''(B) whether or not the discretion described in paragraph (2) is actually exercised.

''(4) The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship.''

Subsec. (z). Pub. L. 103–66, §13603(b), added subsec. (z).

1991—Subsec. (h). Pub. L. 102–234, §3(a), struck out ''to limit the amount of payment adjustments that may be made under a plan under this subchapter with respect to hospitals that serve a disproportionate number of low-income patients with special needs or'' after ''Secretary''.

Subsec. (t). Pub. L. 102–234, §2(b)(1), substituted ''Nothing'' for ''Except as provided in section 1396b(i) of this title, nothing'' and ''taxes of general applicability'' for ''taxes (whether or not of general applicability)''.

1990—Subsec. (a)(10). Pub. L. 101–508, §4713(a)(1)(D), which directed amendment of par. (10) by adding subdiv. (XI), relating to medical assistance available to an individual described in subsection (u)(1), in the matter following subparagraph (E), was executed in the matter following subpar. (F) to reflect the probable intent of Congress and the intervening amendment by Pub. L. 101–508, §4713(a)(1)(A)–(C), which added subpar. (F). See below. Direction by section 4713(a)(1)(D) to strike ''and'' before ''(X)'' could not be executed because ''and'' did not appear after amendment by Pub. L. 101–508, §4402(d)(1). See below.

Pub. L. 101–508, §4402(d)(1), in closing provisions, struck out ''and'' at end of subdiv. (IX), inserted ''and'' at end of subdiv. (X), and added subdiv. (XI) relating to medical assistance to cover costs of premiums, etc.

Subsec. (a)(10)(A)(i)(VII). Pub. L. 101–508, §4601(a)(1)(A), added subcl. (VII).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 101–508, §4601(a)(1)(B), substituted '', clause (i)(VI), or clause (i)(VII)'' for ''or clause (i)(VI)''.

Subsec. (a)(10)(C)(iv). Pub. L. 101–508, §§4711(d)(2), 4755(c)(1)(A), amended cl. (iv) identically, substituting ''through (21)'' for ''through (20)''.

Subsec. (a)(10)(E)(iii). Pub. L. 101–508, §4501(b), added cl. (iii).

Subsec. (a)(10)(F). Pub. L. 101–508, §4713(a)(1)(A)–(C), added subpar. (F).

Subsec. (a)(13)(A). Pub. L. 101–508, §4801(e)(1)(A), inserted ''(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter)'' after ''take into account the costs''.

Subsec. (a)(13)(E). Pub. L. 101–508, §4704(e)(1), repealed Pub. L. 101–239, §6402(c)(2). See 1989 Amendment note below.

Pub. L. 101–508, §4704(a), substituted ''prescribes'' for ''may prescribe'' and ''on the same methodology used

under section 1395*l*(a)(3) of this title'' for ''on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph''.

Subsec. (a)(13)(F). Pub. L. 101–508, § 4711(c)(1)(A), added subpar. (F).

Subsec. (a)(17). Pub. L. 101–508, § 4723(b), inserted '', payments made to the State under section 1396b(f)(2)(B) of this title,'' after ''insurance premiums''.

Subsec. (a)(25)(G). Pub. L. 101–508, § 4402(a)(1), added subpar. (G).

Subsec. (a)(32)(C). Pub. L. 101–508, § 4708(a), added subpar. (C).

Subsec. (a)(41). Pub. L. 101–508, § 4754(a), substituted ''shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board'' for ''shall promptly notify the Secretary''.

Subsec. (a)(54). Pub. L. 101–508, § 4401(a)(2), added par. (54).

Subsec. (a)(55). Pub. L. 101–508, § 4604(b), added par. (55) relating to providing for adjusted payments.

Pub. L. 101–508, § 4602(a), added par. (55) relating to providing for receipt and initial processing of applications.

Subsec. (a)(57). Pub. L. 101–508, § 4751(a)(1), added par. (57).

Subsec. (a)(58). Pub. L. 101–508, § 4752(c), added par. (58) relating to maintaining a list.

Pub. L. 101–508, § 4751(a)(1), added par. (58) relating to providing that a State develop a written description of advance directive laws.

Subsec. (e)(2)(A). Pub. L. 101–508, § 4732(b)(1), inserted ''or with an eligible organization with a contract under section 1395mm of this title'' after ''section 1396b(m)(2)(A) of this title''.

Subsec. (e)(4). Pub. L. 101–508, § 4603(a)(1), inserted ''(or would remain if pregnant)'' after ''remains''.

Subsec. (e)(6). Pub. L. 101–508, § 4603(a)(2), substituted ''In'' for ''At the option of a State, in'', substituted ''the woman shall be deemed to continue to be'' for ''the State plan may nonetheless treat the woman as being'', and inserted at end ''The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r–1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.''

Subsec. (e)(11). Pub. L. 101–508, § 4402(c), added par. (11).

Subsec. (h). Pub. L. 101–508, § 4711(c)(1)(B), inserted before period at end ''or to limit the amount of payment that may be made under a plan under this subchapter for home and community care''.

Subsec. (j). Pub. L. 101–508, §§ 4711(d)(1), 4755(c)(1)(B), amended subsec. (j) identically substituting ''through (22)'' for ''through (21)''.

Subsec. (*l*)(1)(C). Pub. L. 101–508, § 4601(a)(1)(C)(i), inserted ''children'' after ''(C)''.

Subsec. (*l*)(1)(D). Pub. L. 101–508, § 4601(a)(1)(C)(ii), added subpar. (D) and struck out former subpar. (D) which read as follows: ''at the option of the State, children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),''.

Subsec. (*l*)(2)(C). Pub. L. 101–508, § 4601(a)(1)(C)(iii), added subpar. (C) and struck out former subpar. (C) which read as follows: ''If a State elects, under subsection (a)(10)(A)(ii)(IX) of this section, to cover individuals not described in subparagraph (A) or (B) of paragraph (1), for purposes of that paragraph and with respect to individuals not described in such subparagraphs the State shall establish an income level which is a percentage (not more than 100 percent) of the income official poverty line described in subparagraph (A).''

Subsec. (*l*)(3). Pub. L. 101–508, § 4601(a)(1)(C)(iv), inserted '', (a)(10)(A)(i)(VII),'' after ''(a)(10)(A)(i)(VI)''.

Subsec. (*l*)(4)(A). Pub. L. 101–508, § 4601(a)(1)(C)(v), inserted ''or subsection (a)(10)(A)(i)(VII)'' after ''(a)(10)(A)(i)(VI)''.

Subsec. (*l*)(4)(B). Pub. L. 101–508, § 4601(a)(1)(C)(vi), substituted ''(a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII)'' for ''or (a)(10)(A)(i)(VI)''.

Subsec. (m)(1)(B). Pub. L. 101–508, § 4501(e)(2)(A), inserted '', except as provided in paragraph (2)(C)'' after ''program''.

Subsec. (m)(2)(C). Pub. L. 101–508, § 4501(e)(2)(B), added subpar. (C).

Subsec. (r)(1). Pub. L. 101–508, § 4715(a), inserted ''there shall be disregarded reparation payments made by the Federal Republic of Germany and'' after ''under such a waiver''.

Subsec. (r)(2)(A). Pub. L. 101–508, § 4601(a)(1)(D), inserted ''(a)(10)(A)(i)(VII),'' after ''(a)(10)(A)(i)(VI),''.

Subsec. (s). Pub. L. 101–508, § 4604(a), added subsec. (s).

Subsec. (t). Pub. L. 101–508, § 4701(b)(1), added subsec. (t).

Subsec. (u). Pub. L. 101–508, § 4713(a)(2), added subsec. (u).

Subsec. (v). Pub. L. 101–508, § 4724(a), added subsec. (v).

Subsec. (w). Pub. L. 101–508, § 4751(a)(2), added subsec. (w).

Subsec. (x). Pub. L. 101–508, § 4752(a)(1)(A), added subsec. (x).

Subsec. (y). Pub. L. 101–508, § 4755(a)(2), added subsec. (y).

1989—Subsec. (a)(9)(C). Pub. L. 101–239, § 6115(c), substituted ''paragraphs (15) and (16)'' for ''paragraphs (14) and (15)''.

Pub. L. 101–234 repealed Pub. L. 100–360, § 204(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec.(a)(10)(A). Pub. L. 101–239, § 6405(b), substituted ''(1) through (5), (17) and (21)'' for ''(1) through (5) and (17)'' in introductory provisions.

Subsec. (a)(10)(A)(i)(VI). Pub. L. 101–239, § 6401(a)(1), added subcl. (VI).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 101–239, § 6401(a)(2), inserted ''or clause (i)(VI)'' after ''clause (i)(IV)''.

Subsec. (a)(10)(E). Pub. L. 101–239, § 6408(d)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(11)(C). Pub. L. 101–239, § 6406(a)(1), added subpar. (C).

Subsec. (a)(13)(D). Pub. L. 101–239, § 6408(c)(1), substituted ''in amounts no lower than the amounts, using the same methodology, used'' for ''in the same amounts, and using the same methodology, as used'', ''in the case of'' for ''a separate rate may be paid for'', and ''there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual'' for ''to take into account the room and board furnished by such facility''.

Subsec. (a)(13)(E). Pub. L. 101–239, § 6404(c), substituted ''clause (B) or (C) of section 1396d(a)(2) of this title'' for ''section 1396d(a)(2)(B) of this title provided by a rural health clinic''.

Pub. L. 101–239, § 6402(c)(2), which directed insertion of '', and for payment for services described in section 1396d(a)(2)(C) of this title under the plan,'' after ''provided by a rural health clinic under the plan'', was repealed by Pub. L. 101–508, § 4704(e)(1).

Subsec. (a)(30)(A). Pub. L. 101–239, § 6402(a), inserted before semicolon at end ''and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area''.

Subsec. (a)(43)(A). Pub. L. 101–239, § 6403(d)(1), substituted ''section 1396d(r)'' for ''section 1396d(a)(4)(B)''.

Subsec. (a)(43)(D). Pub. L. 101–239, § 6403(b), added subpar. (D).

Subsec. (a)(53). Pub. L. 101–239, § 6406(a)(2)–(4), added par. (53).

Subsec. (e)(7). Pub. L. 101–239, § 6401(a)(8), substituted '', (C), or (D)'' for ''or (C)'' in introductory provisions.

Subsec. (f). Pub. L. 101–239, § 6411(e)(2), inserted ''and section 1396r–5 of this title'' after ''section 1382h(b)(3) of this title''.

Pub. L. 101–239, § 6411(a)(1), inserted ''and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1)'' before '', no State''.

Pub. L. 101–239, § 6408(d)(4)(C), inserted '', except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title),'' after ''section 1382h(b)(3) of this title''.

Subsec. (*l*)(1)(C), (D). Pub. L. 101–239, § 6401(a)(3), added subpars. (C) and (D) and struck out former subpar. (C) which read as follows: ''at the option of the State, children born after September 30, 1983, who have attained one year of age but have not attained 2, 3, 4, 5, 6, 7, or 8 years of age (as selected by the State),''.

Subsec. (*l*)(2)(A)(ii)(II). Pub. L. 101–239, § 6401(a)(4)(A), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: ''July 1, 1990, is 100 percent.''

Subsec. (*l*)(2)(A)(iv). Pub. L. 101–239, § 6401(a)(4)(B), added cl. (iv).

Subsec. (*l*)(2)(B), (C). Pub. L. 101–239, § 6401(a)(5), (6), added subpar. (B), struck out '', or, if less, the percentage established under subparagraph (A)'' after ''not more than 100 percent'' in former subpar. (B), and redesignated former subpar. (B) as (C).

Subsec. (*l*)(3). Pub. L. 101–239, § 6401(a)(6)(A), inserted '', (a)(10)(A)(i)(VI),'' after ''(a)(10)(A)(i)(IV)'' in introductory provisions.

Subsec. (*l*)(3)(C). Pub. L. 101–239, § 6401(a)(6)(B), substituted ''(C), or (D)'' for ''or (C)''.

Subsec. (*l*)(4)(A). Pub. L. 101–239, § 6401(a)(7)(A), inserted ''and for children described in subsection (a)(10)(A)(i)(VI)'' after ''(a)(10)(A)(i)(IV)''.

Subsec. (*l*)(4)(B). Pub. L. 101–239, § 6401(a)(7)(B), inserted ''or (a)(10)(A)(i)(VI)'' after ''(a)(10)(A)(i)(IV)''.

Subsec. (p)(2)(C). Pub. L. 101–239, § 6411(d)(3)(B), added subpar. (C).

Subsec. (r)(2)(A). Pub. L. 101–239, § 6401(a)(9), inserted ''(a)(10)(A)(i)(VI),'' after ''(a)(10)(A)(i)(IV),'' in introductory provisions.

1988—Subsec. (a)(9)(C). Pub. L. 100–360, § 204(d)(3), substituted ''paragraphs (14) and (15)'' for ''paragraphs (13) and (14)''.

Subsec. (a)(10). Pub. L. 100–647, § 8434(b)(1), inserted ''who is only entitled to medical assistance because the individual is such a beneficiary'' after ''section 1396d(p)(1) of this title'' in subdiv. (VIII) of closing provisions.

Pub. L. 100–360, § 302(a)(1)(C), inserted ''(A)(i)(IV) or'' before ''(A)(ii)(X)'' in subdiv. (VII) of closing provisions.

Pub. L. 100–360, § 302(b)(1), added subdiv. (X) in closing provisions.

Subsec. (a)(10)(A)(i)(I). Pub. L. 100–485, § 202(c)(4), substituted ''section 682(e)(6) of this title'' for ''section 614(g) of this title''.

Subsec. (a)(10)(A)(i)(IV). Pub. L. 100–360, § 302(a)(1)(A), added subcl. (IV).

Subsec. (a)(10)(A)(i)(V). Pub. L. 100–485, § 401(d)(1), added subcl. (V).

Subsec. (a)(10)(A)(ii)(VI). Pub. L. 100–360, § 411(k)(17)(B), substituted ''(c), (d), or (e)'' for ''(c) or (d)'' in two places.

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 100–360, § 302(a)(1)(B), amended subcl. (IX) generally. Prior to amendment, subcl. (IX) read as follows: ''subject to subsection (*l*)(4) of this section, who are described in subsection (*l*)(1) of this section;''.

Subsec. (a)(10)(A)(ii)(X). Pub. L. 100–360, § 301(e)(2)(A), struck out ''subject to subsection (m)(3) of this section,'' before ''who are described''.

Subsec. (a)(10)(A)(ii)(XI). Pub. L. 100–360, § 411(k)(5)(B), substituted ''may be more restrictive'' for ''are more restrictive'' and a semicolon for the period at end.

Pub. L. 100–360, § 411(k)(5)(A), amended Pub. L. 100–203, § 4104, see 1987 Amendment note below.

Subsec. (a)(10)(C)(i)(III). Pub. L. 100–360, § 303(e)(1), substituted ''no more restrictive than the methodology'' for ''the same methodology'' in two places.

Subsec. (a)(10)(E). Pub. L. 100–360, § 301(e)(2)(B), struck out ''subject to subsection (m)(3) of this section,'' before ''for making medical''.

Pub. L. 100–360, § 301(a)(1), struck out ''at the option of a State, but'' after ''(E)''.

Subsec. (a)(13)(A). Pub. L. 100–360, § 411(*l*)(3)(J), as added by Pub. L. 100–485, § 608(d)(27)(H), amended Pub. L. 100–203, § 4211(h)(2)(B), see 1987 Amendment note below.

Subsec. (a)(13)(C). Pub. L. 100–360, § 411(*l*)(3)(H)(i), as amended by Pub. L. 100–485, § 608(d)(27)(F), amended Pub. L. 100–203, § 4211(h)(2)(C), see 1987 Amendment note below.

Subsec. (a)(13)(D). Pub. L. 100–360, § 411(*l*)(3)(H)(ii), (iii), as amended by Pub. L. 100–485, § 608(d)(27)(G), amended Pub. L. 100–203, § 4211(h)(2)(D), see 1987 Amendment note below.

Subsec. (a)(15). Pub. L. 100–360, § 301(e)(2)(C), as added by Pub. L. 100–485, § 608(d)(14)(I)(iii), struck out par. (15) which read as follows: ''in the case of eligible individuals 65 years of age or older who are not qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title) but are covered by either or both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;''.

Subsec. (a)(17). Pub. L. 100–360, § 411(k)(10)(G)(ii), amended directory language of Pub. L. 100–203, § 4118(h)(1), see 1987 Amendment note below.

Pub. L. 100–360, § 301(e)(2)(D), formerly § 301(e)(2)(C), as redesignated and amended by Pub. L. 100–485, § 608(d)(14)(I)(i), substituted ''(m)(3), and (m)(4)'' for ''(m)(4), and (m)(5)''.

Subsec. (a)(28)(D)(i). Pub. L. 100–360, § 411(*l*)(3)(E), substituted ''section 1396r(e) of this title'' for ''section 1396r(f) of this title (relating to implementation of nursing facility requirements, including paragraph (6)(B), relating to specification of resident assessment instrument)''.

Subsec. (a)(33)(B). Pub. L. 100–360, § 411(*l*)(6)(C), substituted ''section 1396r(g) of this title'' for ''section 1396r(d) of this title''.

Subsec. (a)(44)(A). Pub. L. 100–360, § 411(*l*)(6)(D), amended Pub. L. 100–203, § 4212(e)(1)(B), see 1987 Amendment note below.

Subsec. (a)(50). Pub. L. 100–360, § 411(n)(4), formerly § 411(n)(3), as redesignated by Pub. L. 100–485, § 608(d)(28), added Pub. L. 100–203, § 9119(d)(1)(A), see 1987 Amendment note below.

Subsec. (a)(51). Pub. L. 100–360, § 303(e)(2)–(4), added par. (51).

Subsec. (a)(52). Pub. L. 100–485, § 303(a)(2), added par. (52).

Subsec. (c). Pub. L. 100–360, § 302(c)(1), amended subsec. (c) generally. Prior to amendment, subsec. (c) read as follows: ''Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter.''

Subsec. (d). Pub. L. 100–360, § 411(k)(7)(C), amended Pub. L. 100–203, § 4113(b)(2)(ii), see 1987 Amendment note below.

Subsec. (e)(1). Pub. L. 100–485, § 303(b)(1), designated existing provisions as subpar. (A), inserted ''subject to subparagraph (B)'' after ''January 1, 1974,'', and added subpar. (B).

Subsec. (e)(2)(A). Pub. L. 100–360, § 411(k)(7)(D), repealed Pub. L. 100–203, § 4113(d)(2), see 1987 Amendment note below.

Pub. L. 100–360, § 411(k)(7)(B), amended Pub. L. 100–203, § 4113(a)(2), see 1987 Amendment note below.

Subsec. (e)(6). Pub. L. 100–360, § 302(e)(1), amended par. (6) generally. Prior to amendment, par. (6) read as follows: ''At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX) of this section, the plan may provide that any woman described in such subsection and subsection (*l*)(1)(A) of this section shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) of this section without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last day of her pregnancy.''

Subsec. (e)(7). Pub. L. 100–360, § 302(e)(2), in introductory provisions, substituted ''In the case'' for ''If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX) of this section, in the case'' and inserted ''or paragraph (2) of section 1396d(n) of this title'', and, in concluding provisions, substituted ''such respective provision'' for ''subsection (a)(10)(A)(ii)(IX) of this section and subsection (*l*)(1) of this section''.

Subsec. (e)(10). Pub. L. 100–485, § 303(d), added par. (10).

Subsec. (f). Pub. L. 100–360, § 411(k)(10)(G)(iv), added Pub. L. 100–203, § 4118(h)(2), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, § 411(*l*)(8)(C), amended Pub. L. 100–203, § 4213(b)(1), see 1987 Amendment note below.

Subsec. (*l*)(1). Pub. L. 100–360, § 302(e)(3)(A), inserted ''any of subclauses (I) through (III) of'' after ''described in'' in concluding provisions.

Subsec. (*l*)(1)(C). Pub. L. 100–360, § 302(a)(2)(A), inserted ''at the option of the State,'' after ''(C)'' and struck out ''and'' after ''1983,''.

Subsec. (*l*)(2)(A). Pub. L. 100–360, § 302(a)(2)(B), as amended by Pub. L. 100–485, § 608(d)(15)(A), designated existing provisions as cl. (i), substituted ''(not less than the percentage provided under clause (ii) and not more than 185 percent)'' for ''(not more than 185 percent)'', and added cls. (ii) and (iii).

Subsec. (*l*)(2)(A)(ii). Pub. L. 100–485, § 608(d)(15)(B)(i), in introductory provisions, substituted ''The'' for ''Subject to clause (iii), the'', and in subcl. (I), inserted ''or, if greater, the percentage provided under clause (iii),''.

Subsec. (*l*)(2)(A)(iii). Pub. L. 100–485, § 608(d)(15)(B)(ii), substituted ''clause (ii)(I)'' for ''clause (ii)'' in introductory provisions and concluding provisions.

Subsec. (*l*)(3). Pub. L. 100–360, § 302(e)(3)(B), inserted ''(a)(10)(A)(i)(IV) or'' after ''of subsection'' in introductory provisions.

Subsec. (*l*)(4). Pub. L. 100–360, § 302(c)(2), (d), added par. (4) and struck out former par. (4) which read as follows:

''(A) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) of this section unless the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are not less than the payment levels in effect under its plan on July 1, 1987.

''(B)(i) A State may not elect, under subsection (a)(10)(A)(ii)(IX) of this section, to cover only individuals described in paragraph (1)(A) or to cover only individuals described in paragraph (1)(B).

''(ii) A State may not elect, under subsection (a)(10)(A)(ii)(IX) of this section, to cover individuals described in subparagraph (C) of paragraph (1) unless the State has elected, under such subsection, to cover individuals described in the preceding subparagraphs of such paragraph.

''(C) A State plan may not provide, in its election of the option of furnishing medical assistance to individuals described in paragraph (1), that such individuals must apply for benefits under part A of subchapter IV of this chapter as a condition of applying for, or receiving, medical assistance under this subchapter.''

Subsec. (m)(3). Pub. L. 100–360, § 301(e)(2)(E), formerly § 301(e)(2)(D), as redesignated and amended by Pub. L. 100–485, § 608(d)(14)(I)(ii), redesignated par. (4) as (3) and struck out former par. (3) which read as follows: ''A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X) of this section or coverage under subsection (a)(10)(E) of this section, unless the plan provides coverage of some or all of the individuals described in subsection (*l*)(1) of this section.''

Subsec. (m)(4). Pub. L. 100–360, § 301(e)(2)(E), formerly § 301(e)(2)(D), as redesignated and amended by Pub. L. 100–485, § 608(d)(14)(I)(ii), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (m)(4)(A). Pub. L. 100–647, § 8434(b)(2), substituted ''section 1396d(p)(1)(B)'' for ''section 1396d(p)(1)(C)''.

Subsec. (m)(5). Pub. L. 100–360, § 301(e)(2)(E), formerly § 301(e)(2)(D), as redesignated and amended by Pub. L. 100–485, § 608(d)(14)(I)(ii), redesignated par. (5) as (4).

Subsec. (*o*). Pub. L. 100–360, § 411(n)(2), made technical correction to directory language of Pub. L. 100–203, § 9115(b), see 1987 Amendment note below.

Subsec. (q). Pub. L. 100–360, § 411(n)(4), formerly § 411(n)(3), as redesignated by Pub. L. 100–485, § 608(d)(28), added Pub. L. 100–203, § 9119(d)(1)(B), see 1987 Amendment note below.

Subsec. (r). Pub. L. 100–360, § 303(e)(5), designated existing provisions as par. (1), redesignated subpars. (A) and (B) as cls. (i) and (ii), respectively, and added par. (2).

Pub. L. 100–360, § 303(d), added subsec. (r).

Subsec. (r)(2)(A). Pub. L. 100–485, § 608(d)(16)(C), substituted '', or (f) or under section 1396d(p) of this title'' for '', or under subsection (f)'' in introductory provisions.

1987—Subsec. (a)(9)(C). Pub. L. 100–203, § 4072(d), substituted ''paragraphs (13) and (14)'' for ''paragraphs (12) and (13)''.

Subsec. (a)(10). Pub. L. 100–203, § 4101(e)(1), substituted ''postpartum, and family planning services'' for ''and postpartum services'' in subdiv. (VII) of closing provisions.

Subsec. (a)(10)(A)(ii)(VI). Pub. L. 100–203, § 4211(h)(1)(A), substituted ''nursing facility or intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility''.

Pub. L. 100–203, § 4102(b)(1), substituted ''subsection (c) or (d) of section 1396n of this title'' for ''section 1396n(c) of this title'' in two places.

Subsec. (a)(10)(A)(ii)(IX), (X). Pub. L. 100–203, § 4118(p)(1), (2), realigned margin of subcls. (IX) and (X).

Subsec. (a)(10)(A)(ii)(XI). Pub. L. 100–203, § 4104, as amended by Pub. L. 100–360, § 411(k)(5)(A), added subcl. (XI).

Subsec. (a)(10)(C)(iv). Pub. L. 100–203, § 4211(h)(1)(B), substituted ''in an intermediate care facility'' for ''intermediate care facility services''.

Subsec. (a)(10)(D). Pub. L. 100–203, § 4211(h)(1)(C), struck out ''skilled'' before ''nursing''.

Subsec. (a)(13)(A). Pub. L. 100–203, § 4211(h)(2)(B), as amended by Pub. L. 100–360, § 411(*l*)(3)(J), as added by Pub. L. 100–485, § 608(d)(27)(H), substituted '', nursing facility, and intermediate care facility for the mentally retarded and'' for '', skilled nursing facility, and intermediate care facility and''.

Pub. L. 100–203, § 4211(h)(2)(A), substituted ''services, nursing facility services, and services in an intermediate care facility for the mentally retarded'' for '', skilled nursing facility, and intermediate care facility services''.

Pub. L. 100–203, § 4211(b)(1)(A), inserted ''which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care,'' after second reference to ''State''.

Subsec. (a)(13)(C). Pub. L. 100–203, § 4211(h)(2)(C), as amended by Pub. L. 100–360, § 411(*l*)(3)(H)(i), as amended

by Pub. L. 100–485, §608(d)(27)(F), substituted ''nursing facilities and for intermediate care facilities for the mentally retarded'' for ''skilled nursing facilities and intermediate care facilities'' in introductory provisions.

Subsec. (a)(13)(D). Pub. L. 100–203, §4211(h)(2)(D), as amended by Pub. L. 100–360, §411(*l*)(3)(H)(ii), (iii), as amended by Pub. L. 100–485, §608(d)(27)(G), substituted ''nursing facility or intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility'' and ''nursing facility services or services in an intermediate care facility for the mentally retarded'' for ''skilled nursing facility services or intermediate care facility services''.

Subsec. (a)(17). Pub. L. 100–203, §4118(p)(3), substituted ''subsections (*l*)(3), (m)(4), and (m)(5)'' for ''subsection (*l*)(3)''.

Pub. L. 100–203, §4118(h)(1), as amended by Pub. L. 100–360, §411(k)(10)(G)(ii), substituted ''(whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof)'' for ''(whether in the form of insurance premiums or otherwise)''.

Subsec. (a)(23). Pub. L. 100–203, §4113(c)(1), designated provision relating to the obtaining of medical assistance by an eligible individual as cl. (A) and added cl. (B).

Pub. L. 100–93, §8(f)(1), inserted ''subsection (g) and in'' after ''as provided in''.

Subsec. (a)(28). Pub. L. 100–203, §4211(b)(1)(B), amended par. (28) generally. Prior to amendment, par. (28) read as follows: ''provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases shall not apply for purposes of this subchapter;''.

Subsec. (a)(30)(B)(i), (ii). Pub. L. 100–203, §4211(h)(3), substituted ''intermediate care facility for the mentally retarded'' for ''skilled nursing facility, intermediate care facility''.

Subsec. (a)(30)(C). Pub. L. 100–203, §4118(p)(4), substituted ''use'' for ''provide''.

Pub. L. 100–203, §4113(b)(1), inserted '', an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary,'' before ''or a private accreditation body''.

Subsec. (a)(31). Pub. L. 100–203, §4212(d)(2), in introductory provision substituted ''services in an intermediate care facility for the mentally retarded (where'' for ''skilled nursing facility services (and with respect to intermediate care facility services where'' and in subpar. (B) substituted ''intermediate care facility for the mentally retarded'' for ''skilled nursing or intermediate care facility''.

Subsec. (a)(33)(B). Pub. L. 100–203, §4212(d)(3), inserted '', except as provided in section 1396r(d) of this title,'' after ''(B) that''.

Subsec. (a)(38). Pub. L. 100–93, §8(f)(2), substituted ''the information described in section 1320a–7(b)(9) of this title'' for ''respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor''.

Subsec. (a)(39). Pub. L. 100–93, §8(f)(3), substituted ''exclude'' for ''bar'', ''individual or entity'' for ''person'' in two places, and inserted reference to section 1320a–7a of this title.

Subsec. (a)(42). Pub. L. 100–203, §4118(m)(1)(B), struck out ''(A)'' after ''provide'', the comma after ''under the plan'', and cls. (B) and (C) which read as follows: ''(B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such subchapter, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1320a–8(a) of this title''.

Subsec. (a)(44). Pub. L. 100–203, §4212(e)(1)(A), substituted ''services in an intermediate care facility for the mentally retarded'' for ''skilled nursing facility services, intermediate care facility services''.

Subsec. (a)(44)(A). Pub. L. 100–203, §4218(a)(1), substituted ''physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies'' for ''physician certifies'' and ''a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician,'' for ''the physician, or a physician assistant or nurse practitioner under the supervision of a physician,''.

Pub. L. 100–203, §4212(e)(1)(B), as amended by Pub. L. 100–360, §411(*l*)(6)(D), substituted ''that are services provided in an intermediate care facility for the mentally retarded'' for ''that are intermediate care facility services provided in an institution for the mentally retarded''.

Subsec. (a)(44)(B). Pub. L. 100–203, §4218(a)(2), substituted ''a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;'' for ''a physician;''.

Subsec. (a)(46). Pub. L. 100–93, §5(a)(1), struck out ''and'' after ''title;''.

Subsec. (a)(47). Pub. L. 100–93, §5(a)(2), (3), substituted semicolon for period at end of par. (47), relating to ambulatory prenatal care and redesignated par. (47), relating to cards evidencing eligibility, as (48).

Subsec. (a)(48). Pub. L. 100–93, §5(a)(3), redesignated par. (47), relating to cards evidencing eligibility for medical assistance, as (48), and substituted ''address; and'' for ''address.''

Subsec. (a)(49). Pub. L. 100–93, §5(a)(4), added par. (49).

Subsec. (a)(50). Pub. L. 100–203, §9119(d)(1)(A), as added by Pub. L. 100–360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100–485, §608(d)(28), added par. (50).

Subsec. (d). Pub. L. 100–203, §4113(b)(2)(i), inserted ''an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, for the performance of the quality review functions described in subsection (a)(30)(C) of this section, or'' after ''contracts with''.

Pub. L. 100–203, §4113(b)(2)(ii), as amended by Pub. L. 100–360, §411(k)(7)(C), substituted ''an entity or organization'' for ''organization (or organizations)'' in two places.

Subsec. (e)(2)(A). Pub. L. 100–203, §4113(d)(2), which directed substitution of ''subparagraph (B)(iii), (E), or (G) of section 1396b(m)(2) of this title'' for ''section 1396a(m)(2)(G) of this title'', was repealed by Pub. L. 100–360, §411(k)(7)(D).

Pub. L. 100–203, §4113(a)(2), as amended by Pub. L. 100–360, §411(k)(7)(B), substituted ''paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title'' for ''section 1396b(m)(2)(G) of this title''.

Pub. L. 100–203, §4113(c)(2), substituted ''but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only'' for ''but only''.

Subsec. (e)(3)(B)(i). Pub. L. 100–203, §4211(h)(4), substituted ''nursing facility, or intermediate care facility

for the mentally retarded'' for ''skilled nursing facility, or intermediate care facility''.

Subsec. (e)(3)(C). Pub. L. 100–203, § 4118(c)(1), substituted ''for medical assistance under the State plan under this subchapter'' for ''to have a supplemental security income (or State supplemental) payment made with respect to him under subchapter XVI of this chapter''.

Subsec. (e)(4). Pub. L. 100–203, § 4101(a)(2), inserted sentence at end relating to child's medical assistance eligibility identification number and submission and payment of claims under such number during period in which a child is eligible for assistance.

Subsec. (e)(5). Pub. L. 100–203, § 4101(e)(2), substituted ''through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends'' for ''until the end of the 60-day period beginning on the last day of her pregnancy''.

Subsec. (e)(7). Pub. L. 100–203, § 4101(b)(2)(B), substituted ''subparagraph (B) or (C)'' for ''subparagraph (B), (C), (D), (E), or (F)''.

Subsec. (e)(9). Pub. L. 100–203, § 4118(p)(6), realigned margins of par. (9).

Subsec. (e)(9)(A)(iii). Pub. L. 100–203, § 4211(h)(5)(A), substituted ''nursing facility, or intermediate care facility for the mentally retarded'' for ''skilled nursing facility, or intermediate care facility,''.

Subsec. (e)(9)(B). Pub. L. 100–203, § 4211(h)(5)(B), substituted ''nursing facilities, or intermediate care facilities for the mentally retarded'' for ''skilled nursing facilities, or intermediate care facilities''.

Subsec. (f). Pub. L. 100–203, § 4118(h)(2), as added by Pub. L. 100–360, § 411(k)(10)(G)(iv), inserted ''regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof'' after ''State law'' in first sentence.

Subsec. (i). Pub. L. 100–203, § 4213(b)(1), as amended by Pub. L. 100–360, § 411(*l*)(8)(C), in par. (1), substituted ''intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility'' and ''the requirements for such a facility under this subchapter'' for ''the provisions of section 1395x(j) of this title or section 1396d(c) of this title, respectively,'', and in pars. (2) and (3), substituted ''the requirements for such a facility under this subchapter'' for ''the provisions of section 1395x(j) of this title or section 1396d(c) of this title (as the case may be)''.

Subsec. (j). Pub. L. 100–203, § 4116, inserted reference to Northern Mariana Islands in two places.

Subsec. (*l*). Pub. L. 100–93, § 7, redesignated subsec. (*l*), relating to disregarding certain benefits for purposes of determining post-eligibility contributions, as (*o*).

Subsec. (*l*)(1). Pub. L. 100–203, § 4118(p)(7), made technical corrections in introductory provisions and substituted ''and whose'' for '', whose'' in closing provisions.

Subsec. (*l*)(1)(C). Pub. L. 100–203, § 4101(c)(2), substituted ''5, 6, 7, or 8 years of age'' for ''or 5 years of age''.

Pub. L. 100–203, § 4101(b)(1), added subpar. (C). Former subpar. (C), which related to children who have attained one year of age but have not attained two years of age, was struck out.

Subsec. (*l*)(1)(D) to (F). Pub. L. 100–203, § 4101(b)(1)(B), struck out subpars. (D) to (F) which related to children who have attained two years of age but have not attained three years of age, children who have attained three years of age but have not attained four years of age, and children who have attained four years of age but have not attained five years of age, respectively.

Subsec. (*l*)(2). Pub. L. 100–203, § 4118(p)(8), struck out ''nonfarm'' after second reference to ''income'' in subpar. (A).

Pub. L. 100–203, § 4101(a)(1)(A), designated existing provisions as subpar. (A), inserted ''with respect to individuals described in subparagraph (A) or (B) of that paragraph'', substituted ''185 percent'' for ''100 percent'', and added subpar. (B).

Subsec. (*l*)(3)(C). Pub. L. 100–203, § 4101(b)(2)(A)(i), substituted ''subparagraph (B) or (C)'' for ''subparagraph (B), (C), (D), (E), or (F)''.

Subsec. (*l*)(3)(D). Pub. L. 100–203, § 4101(a)(1)(B), inserted ''appropriate'' after ''applied is the''.

Subsec. (*l*)(3)(E). Pub. L. 100–203, § 4101(e)(3), inserted ''(except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17))'' after ''subchapter IV''.

Subsec. (*l*)(4)(A). Pub. L. 100–203, § 4101(e)(4), substituted ''July 1, 1987'' for ''April 17, 1986''.

Subsec. (*l*)(4)(B)(ii). Pub. L. 100–203, § 4101(b)(2)(A)(ii), substituted ''subparagraph (C)'' for ''subparagraph (C), (D), (E), or (F)''.

Subsec. (*l*)(4)(C). Pub. L. 100–203, § 4101(e)(5), added subpar. (C).

Subsec. (m)(2)(A). Pub. L. 100–203, § 4118(p)(8), struck out ''nonfarm'' before ''official''.

Subsec. (*o*). Pub. L. 100–203, § 9115(b), as amended by Pub. L. 100–360, § 411(n)(2), substituted ''subparagraph (E) or (G) of section 1382(e)(1) of this title'' for ''section 1382(e)(1)(E) of this title''.

Pub. L. 100–93, § 7, redesignated subsec. (*l*), relating to disregarding certain benefits for purposes of determining post-eligibility contributions, as (*o*).

Subsec. (p). Pub. L. 100–93, § 7, added subsec. (p).

Subsec. (q). Pub. L. 100–203, § 9119(d)(1)(B), as added by Pub. L. 100–360, § 411(n)(4), formerly § 411(n)(3), as redesignated by Pub. L. 100–485, § 608(d)(28), added subsec. (q).

1986—Subsec. (a). Pub. L. 99–509, § 9406(b), inserted at end ''Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title.''

Pub. L. 99–272, § 9529(a)(1), inserted at end ''For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV in the State where such child resides.''

Subsec. (a)(9)(C). Pub. L. 99–509, § 9320(h)(3), substituted ''paragraphs (12) and (13)'' for ''paragraphs (11) and (12)''.

Subsec. (a)(10). Pub. L. 99–509, § 9408(b), added cl. (IX) at end.

Pub. L. 99–509, § 9403(c), added cl. (VIII) at end.

Pub. L. 99–509, § 9401(c), added cl. (VII) at end.

Pub. L. 99–272, § 9505(b)(1), added cl. (VI) at end.

Pub. L. 99–272, § 9501(b), added cl. (V) at end.

Subsec. (a)(10)(A)(i)(I). Pub. L. 99–272, § 12305(b)(3), substituted '', 606(h), or 673(b) of this title'' for ''or 606(h) of this title''.

Subsec. (a)(10)(A)(i)(II). Pub. L. 99–509, § 9404(a), inserted ''or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title)'' after ''subchapter XVI''.

Subsec. (a)(10)(A)(ii)(V). Pub. L. 99–272, § 9510(a), inserted ''for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period)'' after ''are in a medical institution''.

Subsec. (a)(10)(A)(ii)(VII). Pub. L. 99–514, § 1895(c)(7)(A), realigned margin of subcl. (VII).

Pub. L. 99–272, § 9505(b)(2), added subcl. (VII).

Subsec. (a)(10)(A)(ii)(VIII). Pub. L. 99–514, § 1895(c)(7)(B), realigned margins of subcl. (VIII).

Pub. L. 99–272, § 9529(b)(1), added subcl. (VIII).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 99–509, § 9401(a), added subcl. (IX).

Subsec. (a)(10)(A)(ii)(X). Pub. L. 99–509, § 9402(a)(1), added subcl. (X).

Subsec. (a)(10)(C). Pub. L. 99–509, § 9403(g)(1), inserted ''or (E)'' after ''subparagraph (A)'' in introductory text.

Subsec. (a)(10)(C)(iv). Pub. L. 99–509, § 9408(c)(3), substituted ''through (20)'' for ''through (19)''.

Pub. L. 99–514, § 1895(c)(3)(C), substituted ''through (19)'' for ''through (18)''.

Pub. L. 99–272, § 9505(d)(2), substituted ''through (18)'' for ''through (17)''.

Subsec. (a)(10)(E). Pub. L. 99–509, §9403(a), added subpar. (E).

Subsec. (a)(13)(B). Pub. L. 99–272, §9509(a)(1), substituted ''hospitals'' for ''hospitals, skilled nursing facilities, and intermediate care facilities''.

Subsec. (a)(13)(C). Pub. L. 99–272, §9509(a)(4), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 99–272, §9505(c)(1), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (a)(13)(D). Pub. L. 99–514, §1895(c)(1), inserted ''and'' after ''facility;''.

Pub. L. 99–509, §9435(b)(1), inserted ''and for payment of amounts under section 1396d(*o*)(3) of this title'' before first semicolon.

Pub. L. 99–272, §9509(a)(2), (3), redesignated former subpar. (C) as (D), and struck out ''and'' at the end thereof. Former subpar. (D) redesignated (E).

Pub. L. 99–272, §9505(c)(1)(B), redesignated former subpar. (C) as (D).

Subsec. (a)(13)(E). Pub. L. 99–272, §9509(a)(3), redesignated former subpar. (D) as (E).

Subsec. (a)(15). Pub. L. 99–509, §9403(g)(4)(A), inserted ''are not qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title) but'' after ''older who''.

Subsec. (a)(17). Pub. L. 99–509, §9401(e)(1), inserted ''except as provided in subsection (*l*)(3)'' after ''(17)''.

Subsec. (a)(25). Pub. L. 99–272, §9503(a)(1), amended par. (25) generally. Prior to amendment, par. (25) read as follows: ''provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;''.

Subsec. (a)(30)(C). Pub. L. 99–509, §9431(a), added subpar. (C).

Subsec. (a)(47). Pub. L. 99–570 added par. (47) relating to cards evidencing eligibility for medical assistance.

Pub. L. 99–509, §9407(a), added par. (47) relating to ambulatory prenatal care.

Subsec. (b)(2). Pub. L. 99–509, §9405, inserted before semicolon '', regardless of whether or not the residence is maintained permanently or at a fixed address''.

Subsec. (d). Pub. L. 99–509, §9431(b)(1), inserted ''(including quality review functions described in subsection (a)(30)(C) of this section)'' after ''medical or utilization review functions''.

Subsec. (e)(2)(A). Pub. L. 99–272, §9517(b)(1), inserted reference to an entity described in section 1396b(m)(2)(G) of this title, and substituted ''such organization or entity'' for ''such organization''.

Subsec. (e)(2)(B). Pub. L. 99–272, §9517(b)(2), substituted ''an organization or entity'' for ''a health maintenance organization'' and ''the organization or entity'' for ''the organization''.

Subsec. (e)(5). Pub. L. 99–272, §9501(c), added par. (5).

Subsec. (e)(6), (7). Pub. L. 99–509, §9401(d), added pars. (6) and (7).

Subsec. (e)(8). Pub. L. 99–509, §9403(f)(2), added par. (8).

Subsec. (e)(9). Pub. L. 99–509, §9408(a), added par. (9).

Subsec. (f). Pub. L. 99–643, §7(b), substituted ''subsection (e) and section 1382h(b)(3) of this title'' for ''subsection (e)''.

Subsec. (g). Pub. L. 99–272, §9503(a)(2), added subsec. (g).

Subsec. (h). Pub. L. 99–509, §9433(a), added subsec. (d) to section 2173 of Pub. L. 97–35, which in turn added subsec. (h) of this section. See 1981 Amendment note below.

Subsec. (j). Pub. L. 99–509, §9408(c)(2), substituted ''(21)'' for ''(20)''.

Pub. L. 99–514, §1895(c)(3)(B), substituted ''(20)'' for ''(19)''.

Pub. L. 99–272, §9505(d)(1), substituted ''(19)'' for ''(18)''.

Subsec. (k). Pub. L. 99–272, §9506(a), added subsec. (k).

Subsec. (*l*). Pub. L. 99–643, §3(b), added subsec. (*l*) relating to disregarding of certain benefits for purposes of determining post-eligibility contributions.

Pub. L. 99–509, §9401(b), added subsec. (*l*) relating to description of group.

Subsec. (m). Pub. L. 99–509, §9402(a)(2), (b), added subsec. (m).

Subsec. (m)(3). Pub. L. 99–509, §9403(f)(1)(A), which directed insertion of ''or coverage under subsection (a)(10)(E) of this section'' after ''subsection (a)(10)(A)(ii)(IX) of this section'', was executed by making the insertion after ''subsection (a)(10)(A)(ii)(X) of this section'' as the probable intent of Congress.

Subsec. (m)(5). Pub. L. 99–509, §9403(f)(1)(B), added par. (5).

Subsec. (n). Pub. L. 99–509, §9403(e), added subsec. (n).

1984—Subsec. (a)(9)(C). Pub. L. 98–369, §2373(b)(1), realigned margin of subpar. (C).

Subsec. (a)(10)(A). Pub. L. 98–369, §2373(b)(2), realigned margins of subpar. (A).

Subsec. (a)(10)(A)(i). Pub. L. 98–369, §2361(a), amended cl. (i) generally. Prior to the amendment cl. (i) read as follows: ''all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; and''.

Subsec. (a)(10)(A)(i)(I). Pub. L. 98–378, §20(c), substituted ''section 602(a)(37) or 606(h) of this title'' for ''section 602(a)(37) of this title''.

Subsec. (a)(13)(A). Pub. L. 98–369, §2373(b)(3), made clarifying amendment by striking out ''(A)'' and all that follows through ''hospital'' the first place it appears and inserting in lieu thereof ''(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital'', resulting in no change in text.

Subsec. (a)(13)(B), (C). Pub. L. 98–369, §2314(b), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(20)(B). Pub. L. 98–369, §2373(b)(4), substituted ''periodic'' for ''periodical''.

Subsec. (a)(20)(C). Pub. L. 98–369, §2373(b)(5), struck out reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(26). Pub. L. 98–369, §2368(b), in amending par. (26) generally, revised existing provisions to continue their application to review of inpatient mental hospital service programs, and to sever provisions relating to review of skilled nursing programs. See par. (31) of this section.

Subsec. (a)(26)(B)(ii). Pub. L. 98–617, §3(a)(7), repealed the amendment made by Pub. L. 98–369, §2373(b)(6). See below.

Pub. L. 98–369, §2373(b)(6), provided that cl. (ii) is amended by substituting ''facilities'' for ''homes''.

Subsec. (a)(26)(C). Pub. L. 98–617, §3(b)(10), realigned margin of subpar. (C).

Subsec. (a)(28). Pub. L. 98–369, §2335(e), struck out ''and tuberculosis'' after ''mental diseases''.

Subsec. (a)(30). Pub. L. 98–369, §2363(a)(1)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(31). Pub. L. 98–369, §2368(a), in amending par. (31) generally, revised existing provisions to cover review of skilled nursing facilities.

Subsec. (a)(33)(A). Pub. L. 98–369, §2373(b)(7), substituted ''second sentence'' for ''penultimate sentence''.

Subsec. (a)(42). Pub. L. 98–369, § 2373(b)(8), substituted ''subchapter'' for ''part'' after ''audits conducted for purposes of such''.

Subsec. (a)(43). Pub. L. 98–369, § 2303(g)(1), redesignated par. (44) as (43), and struck out former par. (43) which provided that if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician, or other physician with whom he shares his practice, did not personally perform or supervise, the plan include provision to insure that payment for such services not exceed the payment authorized by section 1395u(h) of this title.

Subsec. (a)(44). Pub. L. 98–369, § 2363(a)(1)(B), added par. (44).

Pub. L. 98–369, § 2303(g)(1)(C), redesignated former par. (44) as (43).

Subsec. (a)(45). Pub. L. 98–369, § 2367(a), added par. (45).

Subsec. (a)(46). Pub. L. 98–369, § 2651(c), added par. (46).

Subsec. (a), foll. par. (46). Pub. L. 98–369, § 2373(b)(9), substituted ''The provisions of paragraph (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to'' for ''For purposes of paragraph (9)(A), (26), (31), and (33), and of section 1396b(i)(4) of this title, the term 'skilled nursing facility' and 'nursing home' do not include''.

Subsec. (e)(4). Pub. L. 98–369, § 2362(a), added par. (4).

Subsec. (f). Pub. L. 98–369, § 2373(b)(10), substituted ''paragraph (10)(A)'' and ''paragraph (10)(C)'' for ''clause (10)(A)'' and ''clause (10)(C)'', respectively, wherever appearing.

1982—Subsec. (a)(10). Pub. L. 97–248, § 131(c), formerly § 131(b), as redesignated by Pub. L. 97–448, § 309(a)(8), in provisions following subpar. (D) added cl. (IV).

Subsec. (a)(10)(A). Pub. L. 97–248, § 137(b)(7), redesignated existing provisions as provisions preceding cl. (i) and cl. (i), and added cl. (ii).

Subsec. (a)(10)(C), (D). Pub. L. 97–248, § 137(a)(3), amended directory language of Pub. L. 97–35, § 2171(a)(3), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (a)(10)(C)(i). Pub. L. 97–248, § 137(b)(8), substituted '', (II)'' for ''and (II)'', and added subcl. (III).

Subsec. (a)(10)(C)(ii)(I). Pub. L. 97–248, § 137(b)(9), substituted ''under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i)'' for ''described in section 1396d(a)(i) of this title''.

Subsec. (a)(14). Pub. L. 97–248, § 131(a), substituted provisions that a State plan for medical assistance must provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396*o* of this title for provisions that such plan must provide that, with respect to individuals receiving assistance, no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in pars. (1) through (5), (7), and (17) of section 1396d(a) of this title, would be imposed under the plan, and any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services would be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and with respect to individuals not receiving assistance, there could be imposed an enrollment fee, premium, or similar charge (as determined in accordance with standards prescribed by the Secretary) related to the individual's income, and any deductible, cost-sharing, or similar charge imposed under the plan would be nominal.

Subsec. (a)(18). Pub. L. 97–248, § 132(a), substituted provisions that a State plan for medical assistance must comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets for provisions that such plan must provide that no lien could be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there would be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he had no surviving child who was under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), was blind or permanently and totally disabled, or was blind or disabled as defined in section 1382c of this title with respect to States which were not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan.

Subsec. (a). Pub. L. 97–248, § 137(e), inserted '', (26)'' after ''(9)(A)'' in provisions following par. (44).

Subsec. (b)(2) to (4). Pub. L. 97–248, § 137(b)(10), struck out par. (2) which provided that the Secretary would not approve any plan which imposed any age requirement which excluded any individual who had not attained the age of 19 and was a dependent child under part A of subchapter IV of this chapter, and redesignated pars. (3) and (4) as (2) and (3), respectively.

Subsec. (d). Pub. L. 97–248, § 146(a), substituted references to utilization and quality control peer review organizations having a contract with the Secretary, for references to conditionally or otherwise designated Professional Standards Review Organizations, wherever appearing.

Subsec. (e)(3). Pub. L. 97–248, § 134(a), added par. (3).

Subsec. (j). Pub. L. 97–248, §§ 132(c), 136(d), struck out subsec. (j) which related to the denial of medical assistance under a State plan because of an individual's disposal of resources for less than fair market value, the period of ineligibility, and the eligibility of certain individuals for medical assistance under a State plan who would otherwise be ineligible because of the provisions of section 1382b(c) of this title, and added a new subsec. (j) relating to waiver or modification of requirements with respect to American Samoa medical assistance program.

1981—Subsec. (a)(9)(C). Pub. L. 97–35, § 2175(d)(1)(C), added subpar. (C).

Subsec. (a)(10)(A). Pub. L. 97–35, § 2171(a)(1), substituted ''including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized by section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title)'' for ''to all individuals receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI, or part A of subchapter IV of this chapter''.

Subsec. (a)(10)(B). Pub. L. 97–35, § 2171(a)(2), substituted reference to subparagraph for reference to clause in two places.

Subsec. (a)(10)(C). Pub. L. 97–35, § 2171(a)(3), as amended by Pub. L. 97–248, § 137(a)(3), substituted provisions relating to plans for medical assistance included for any group of individuals described in section 1396d(a) of this title who are not described in subpar. (A) for provisions relating to medical assistance for any group of individuals not described in subpar. (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplementary security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary.

Subsec. (a)(10)(D). Pub. L. 97–35, § 2171(a)(3), as amended by Pub. L. 97–248, § 137(a)(3), added subpar. (D).

Subsec. (a)(11). Pub. L. 97–35, § 2193(c)(9), substituted ''under (or through an allotment under) subchapter V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment'' for ''for

part or all of the cost of plans or projects under subchapter V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V''.

Subsec. (a)(13)(A). Pub. L. 97–35, §§2171(b), 2173(a)(1)(B), (C), struck out subpar. (A) which provided that a State plan must provide for the inclusion of some institutional and some noninstitutional care and services and for the inclusion of home health services for any individual who is entitled to skilled nursing facility services, redesignated subpar. (E) as (A), and in subpar. (A), as so redesignated, made the subsection applicable to hospital facilities, inserted reference to rates which take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1395x(v)(1)(G) of this title, for lower reimbursement rates reflecting the level of care actually received in a manner consistent with such section, and substituted ''safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality'' for ''safety standards''.

Subsec. (a)(13)(B). Pub. L. 97–35, §§2171(b), 2173(a)(1)(C), struck out subpar. (B) which provided that a State plan must provide in the case of individuals 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, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, and redesignated subpar. (F) as (B).

Subsec. (a)(13)(C). Pub. L. 97–35, §2171(b), struck out subpar. (C) which provided for care and services of individuals not included in former subpar. (B).

Subsec. (a)(13)(D). Pub. L. 97–35, §2173(a)(1)(A), struck out subpar. (D) which provided for payment of reasonable cost of inpatient hospital services provided under the plan with provisions for determination of such costs with certain maximum limitations and for payment of reasonable cost of inappropriate inpatient services described in subsec. (h)(1) of this section.

Subsec. (a)(13)(E), (F). Pub. L. 97–35, §2173(a)(1)(C), redesignated subpars. (E) and (F) as (A) and (B), respectively.

Subsec. (a)(20)(D). Pub. L. 97–35, §2173(a)(2), struck out subpar. (D) which required provision for methods of determining reasonable cost of institutional care of such patients.

Subsec. (a)(23). Pub. L. 97–35, §2175(a), substituted ''except as provided in section 1396n and except in the case of'' for ''except in the case of'', and struck out provision that a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or pars. (1) and (10) of this subsection solely by reason of the fact that the State or any political subdivision thereof has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic.

Subsec. (a)(25)(C). Pub. L. 97–35, §2182, substituted ''of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State'' for ''of the individual, the State''.

Subsec. (a)(30). Pub. L. 97–35, §2174(a), substituted ''that payments are consistent'' for ''that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent''.

Subsec. (a)(39). Pub. L. 97–35, §2105(c), substituted ''person'' for ''individual'' in two places.

Subsec. (a)(44). Pub. L. 97–35, §2181(a)(2)(C), added par. (44).

Subsec. (b)(2). Pub. L. 97–35, §2172(a), substituted ''any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of subchapter IV of this chapter;'' for ''effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 606(a)(2) of this title, be a dependent child under part A of subchapter IV of this chapter; or''.

Subsec. (d). Pub. L. 97–35, §2113(m), added subsec. (d).

Subsec. (e). Pub. L. 97–35, §2178(b), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 97–35, §2173(b)(1), (d), as amended by Pub. L. 99–509, §9433(a), added a new subsec. (h) and repealed former subsec. (h) which related to skilled nursing and intermediate care facility services.

1980—Subsec. (a)(13)(B). Pub. L. 96–499, §965(b)(1), substituted ''paragraphs (1) through (5) and (17)'' for ''clauses (1) through (5)''.

Subsec. (a)(13)(C)(i). Pub. L. 96–499, §965(b)(2), substituted ''paragraphs (1) through (5) and (17)'' for ''clauses (1) through (5)''.

Subsec. (a)(13)(C)(ii). Pub. L. 96–499, §965(b)(3), substituted ''paragraphs numbered (1) through (17)'' for ''clauses numbered (1) through (16)''.

Subsec. (a)(13)(D). Pub. L. 96–499, §902(b)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(13)(D)(i). Pub. L. 96–499, §§903(b), 905(a), inserted ''(except where the State agency is subject to an order under section 1396m of this title)'' after ''payment'' and '', except that in the case of hospitals reimbursed for services under part A of subchapter XVIII of this chapter in accordance with section 1395f(b)(3) of this title, the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section'' after ''subchapter XVIII of this chapter''.

Subsec. (a)(13)(E). Pub. L. 96–499, §905(a), inserted ''(except where the State agency is subject to an order under section 1396m of this title)''.

Pub. L. 96–499, §962(a), substituted provisions which required a State plan for medical assistance to provide for payment of skilled nursing facility and intermediate care facility services provided under such plan through the use of rates determined in accordance with methods and standards developed by the State rather than on a reasonable cost related basis, required the filing of uniform cost reports by each facility, and required periodic audits of such reports by the State.

Subsec. (a)(14)(A)(i). Pub. L. 96–499, §965(b)(4), substituted ''paragraphs (1) through (5), (7), and (17)'' for ''clauses (1) through (5) and (7)''.

Subsec. (a)(33)(B). Pub. L. 96–499, §916(b)(1)(B), inserted exception authorizing the Secretary where there was cause to question the adequacy of participation determinations to make independent determinations concerning the extent to which individual institutions and agencies met the requirements for participation.

Subsec. (a)(35). Pub. L. 96–499, §912(b), substituted ''disclosing entity (as defined in section 1320a–3(a)(2) of this title)'' for ''intermediate care facility''.

Subsec. (a)(39). Pub. L. 96–499, §913(c), substituted provisions requiring that State plans for medical assistance authorize the State agency to bar specified individuals from participation in the program under the State plan when required by the Secretary to do so pursuant to section 1320a–7 of this title for provisions requiring that State plans for medical assistance provide for the suspension of physicians or other individuals from participation in the State plan upon notification by the Secretary that such physician or other individual had been suspended from participation in the plan under subchapter XVIII of this chapter.

Subsec. (a)(41). Pub. L. 96–272 added par. (41).

Subsec. (a)(42). Pub. L. 96–499, §914(b)(1), added par. (42).

Subsec. (a)(43). Pub. L. 96–499, § 918(b)(1)(C), added par. (43).

Subsec. (g). Pub. L. 96–499, § 913(d), struck out subsec. (g) which related to waiver of suspension of payments to physicians or practitioners suspended from participation in approved State plans.

Subsec. (h). Pub. L. 96–499, § 902(b)(2), added subsec. (h).

Subsec. (i). Pub. L. 96–499, § 916(b)(1)(A), added subsec. (i).

Subsec. (j). Pub. L. 96–611 added subsec. (j).

1978—Subsec. (a)(4)(C). Pub. L. 95–559 added cl. (C).

1977—Subsec. (a)(13)(F). Pub. L. 95–210, § 2(c)(1), added subpar. (F).

Subsec. (a)(23). Pub. L. 95–210, § 2(c)(2), inserted ‘‘, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic’’ after ‘‘who elect to obtain such care and services from such organization’’.

Subsec. (a)(26). Pub. L. 95–142, § 20(b), inserted provision relating to staff of skilled nursing facilities.

Subsec. (a)(27)(B). Pub. L. 95–142, § 9, inserted ‘‘or the Secretary’’ after ‘‘State agency’’ wherever appearing.

Subsec. (a)(32). Pub. L. 95–142, § 2(a)(3), substituted provisions relating to terms, conditions, etc., for payments under an assignment or power of attorney, for provisions relating to terms, conditions, etc., for payments to anyone other than the individual receiving any care or service provided by a physician, dentist, or other individual practitioner, or such physician, dentist, or practitioner.

Subsec. (a)(35). Pub. L. 95–142, § 3(c)(1)(A), substituted provisions relating to requirements for intermediate care facilities to comply with section 1320a–3 of this title for provisions relating to disclosure requirements, effective Jan. 1, 1973, applicable to intermediate care facilities with respect to ownership, corporate, status, etc.

Subsec. (a)(37). Pub. L. 95–142, §§ 2(b)(1)(C), 3(c)(1)(C), 7(b)(1), added subsec. (a)(37) and made and struck out minor changes in phraseology, necessitating no changes in text.

Subsec. (a)(38). Pub. L. 95–142, §§ 3(c)(1)(D), 7(b)(2), 19(b)(2)(A), added par. (38) and made and struck out minor changes in phraseology necessitating no changes in text.

Subsec. (a)(39). Pub. L. 95–142, §§ 7(b)(3), 19(b)(2)(B), added par. (39).

Subsec. (a)(40). Pub. L. 95–142, § 19(b)(2)(C), added par. (40).

Subsec. (a), foll. par. (40). Pub. L. 95–142, § 2(b)(1)(D), added paragraph relating to waiver of requirement of cl. (A) of par. (37).

Subsec. (g). Pub. L. 95–142, § 7(c), added subsec. (g).

1976—Subsec. (g). Pub. L. 94–552 struck out provisions for consent to suit and waiver of immunity by State.

1975—Subsec. (a). Pub. L. 94–48, § 1, added undesignated paragraph at end of subsec. (a) relating to eligibility under this subchapter of any individual who was eligible for the month of August 1972, under a State plan approved under subchapters I, X, XIV, XVI, or part A of subchapter IV of this chapter if such individual would have been eligible for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Pub. L. 92–336 not been applicable to such individual.

Subsec. (a)(23). Pub. L. 94–48, § 2, inserted ‘‘except in the case of Puerto Rico, the Virgin Islands, and Guam,’’.

Subsec. (g). Pub. L. 94–182 added subsec. (g).

1974—Subsec. (a)(14)(B)(i). Pub. L. 93–368 substituted ‘‘may’’ for ‘‘shall’’.

1973—Subsec. (a)(5). Pub. L. 93–233, § 13(a)(2)(A), (B), substituted ‘‘to administer or to supervise the administration of the plan’’ for ‘‘to administer the plan’’ and ‘‘to supervise the administration of the plan’’ in that order and inserted after the parenthetical phrase the conditional provision ‘‘if the State is eligible to participate in the State plan program established under subchapter XVI, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV if the State is not eligible to participate in the State plan program established under subchapter XVI’’.

Subsec. (a)(10). Pub. L. 93–233, § 13(a)(3), incorporated existing text in provisions designated as cl. (A), providing therein for medical assistance to individuals with respect to whom supplemental security income benefits are paid; incorporated existing par. (A) in provisions designated as cl. (B); incorporated existing par. (B) in provisions designated as cl. (C), providing therein for individuals not meeting income and resources requirements of the supplemental security income program; substituted in cls. (B)(ii), (C), (C)(i)(ii) and ‘‘medical assistance’’ for ‘‘medical or remedial care and services’’ appearing in predecessor provisions and in cl. (C)(i) ‘‘except for income and resources’’ for ‘‘if needy’’ appearing in predecessor provision; and in the exception provisions included reference to par. (16) of section 1396(a) of this title in item (I), substituted ‘‘deductibles’’ for ‘‘the deductibles’’ in item (II), and added item (III).

Subsec. (a)(13)(B). Pub. L. 93–233, § 13(a)(4), substituted ‘‘any plan of the State approved’’ for ‘‘the State’s plan approved’’ and inserted after ‘‘part A of subchapter IV of this chapter’’ text reading ‘‘, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter’’.

Subsec. (a)(13)(C)(ii)(I). Pub. L. 93–233, § 18(x)(1), substituted reference to cl. ‘‘16’’ for ‘‘14’’.

Subsec. (a)(14)(A). Pub. L. 93–233, § 13(a)(5), substituted ‘‘any plan of the State approved’’ for ‘‘a State plan approved’’ and ‘‘with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)’’ for ‘‘who meet the income and resources requirements of the one of such State plans which is appropriate’’.

Subsec. (a)(14)(B). Pub. L. 93–233, § 13(a)(6)(A)–(D), inserted after ‘‘with respect to individuals’’ the parenthetical provision ‘‘(other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A))’’; inserted after ‘‘any such State plan’’ the clause ‘‘and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter’’; substituted ‘‘the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be,’’ for ‘‘the one of such State plans which is appropriate’’; and struck out ‘‘or who, after December 31, 1973, are included under the State plan for medical assistance pursuant to subsection (a)(10)(B) of this section approved under this subchapter’’ preceding the hyphen and cl. (i), respectively.

Subsec. (a)(17). Pub. L. 93–233, § 13(a)(7)(A)–(D), (8), substituted: ‘‘any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI’’ for ‘‘the State’s plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV’’; ‘‘except for income and resources’’ for ‘‘if he met the requirements as to need’’; ‘‘any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of sub-

chapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI'' for ''a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV''; ''such aid, assistance, or benefits'' for ''and amount of such aid or assistance under such plan''; and ''(with respect to States eligible to participate in the State program established under subchapter XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)'' for ''is blind or permanently and totally disabled''.

Subsec. (a)(18). Pub. L. 93–233, §13(a)(8), substituted ''(with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)'' for ''is blind or permanently and totally disabled''.

Subsec. (a)(20)(C). Pub. L. 93–233, §13(a)(9), inserted reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(21), (24). Pub. L. 93–233, §18(x)(4), provided for substitution of ''nursing facilities'' for ''nursing homes''.

Subsec. (a)(26)(B). Pub. L. 93–233, §18(x)(4), provided for substitution of ''nursing facility'' and ''nursing facilities'' for ''nursing home'' and ''nursing homes'', changes already executed under 1972 Amendment by Pub. L. 92–603, §278(a)(19).

Subsec. (a)(33)(A). Pub. L. 93–233, §18(x)(2), substituted ''penultimate sentence'' for ''last sentence''.

Subsec. (a)(34). Pub. L. 93–233, §18(*o*), inserted ''(or application was made on his behalf in the case of a deceased individual)'' after ''he made application''.

Subsec. (a)(35)(A). Pub. L. 93–233, §18(p), required the intermediate care facility to supply full and complete information respecting the person who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the intermediate care facility or any of the property or assets of the intermediate care facility.

Subsec. (a)(35) to (37). Pub. L. 93–233, §18(x)(3)(A), (B), substituted ''; and'' for ''.'' at end of par. (35); and corrected numerical sequence of paragraphs, redesignating par. (37) as (36), the original subsec. (a) having been enacted without a par. (36).

Subsec. (e). Pub. L. 93–233, §18(q), substituted ''each family which was receiving aid pursuant to a plan of the State approved under part A'' for ''each family which was eligible for assistance pursuant to part A'', ''for such aid because of increased hours of, or increased income from, employment'' for ''for such assistance because of increased income from employment'', and ''remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations'' for ''remain eligible for such assistance for 4 calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of the income and resources limitations''.

Subsec. (f). Pub. L. 93–233, §13(a)(10)(A)–(D), substituted: ''no State not eligible to participate in the State plan program established under subchapter XVI'' for ''no State'' and ''any supplemental security income payment and State supplementary payment made with respect to such individual'' for ''such individual's payment under subchapter XVI'' and ''as recognized under State law'' for ''as defined in section 213 of Title 26'' in parenthetical text; and inserted two end sentences for consideration of certain individuals as eligible for medical assistance under cl. (10)(A) or (C) of subsec. (a) of this section or as eligible for such assistance under cl. (10)(A) in States not providing such assistance under cl. (10)(C), respectively.

1972—Subsec. (a). Pub. L. 92–603, §§268(a), 278(b)(14), inserted provisions exempting Christian Science sanatoriums from certain nursing facility and nursing home requirements.

Subsec. (a)(9). Pub. L. 92–603, §239(a), inserted provisions to utilize State health agency for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services.

Subsec. (a)(13)(A)(ii), (C). Pub. L. 92–603, §278(a)(18), (b)(14), substituted ''skilled nursing facility'' for ''skilled nursing home''.

Subsec. (a)(13)(D). Pub. L. 92–603, §§221(c)(5), 232(a), inserted provisions that the reasonable cost of inpatient hospital services shall not exceed the amount determined under section 1395x(v) of this title and inserted reference to the consistency of methods and standards with section 1320a–1 of this title for determining the reasonable cost of inpatient hospital services.

Subsec. (a)(13)(E). Pub. L. 92–603, §249(a), added subpar. (E).

Subsec. (a)(14). Pub. L. 92–603, §208(a), substituted a nominal amount for an amount reasonably related to the recipient's income as the amount of the deduction, cost sharing, or similar charge imposed under the plan and inserted provisions covering individuals who are not receiving aid or assistance under any state plan and who do not meet the income and resources requirements and covering individuals who are included under the state plan for medical assistance pursuant to subsec. (a)(10)(B) of this section approved under this subchapter.

Subsec. (a)(23). Pub. L. 92–603, §240, inserted provisions allowing States to adopt comprehensive health care programs while still complying with medicaid requirements.

Subsec. (a)(26). Pub. L. 92–603, §§274(a), 278(a)(19), (b)(14), substituted ''evaluation)'' for ''evaluation'' and ''care'' for ''care)'' and substituted ''skilled nursing facility'' and ''skilled nursing facilities'' for ''skilled nursing home'' and ''skilled nursing homes''.

Subsec. (a)(28). Pub. L. 92–603, §§246(a), 278(a)(20), substituted ''skilled nursing facility'' for ''skilled nursing home'' and substituted a simple reference to the requirements contained in section 1395x(j) of this title with a specified exception for provisions spelling out in detail the requirements for skilled nursing homes receiving payments.

Subsec. (a)(30). Pub. L. 92–603, §237(a)(2), substituted ''under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title)'' for ''under the plan''.

Subsec. (a)(31)(A). Pub. L. 92–603, §298, struck out ''which provides more than a minimum level of health care services'' after ''intermediate care facility''.

Subsec. (a)(32). Pub. L. 92–603, §236(b)(3), added par. (32).

Subsec. (a)(33). Pub. L. 92–603, §239(b)(3), added par. (33).

Subsec. (a)(34). Pub. L. 92–603, §255(a)(3), added par. (34).

Subsec. (a)(35). Pub. L. 92–603, §299A(3), added par. (35).

Subsec. (a)(37). Pub. L. 92–603, §299D(b)(3), added par. (37).

Subsec. (d). Pub. L. 92–603, §231, repealed subsec. (d) which related to modification of state plans for medical assistance under certain circumstances.

Subsec. (e). Pub. L. 92–603, §209(a), added subsec. (e).

Subsec. (f). Pub. L. 92–603, §209(b)(1), added subsec. (f).

1971—Subsec. (a)(31). Pub. L. 92–223 added par. (31).

1969—Subsec. (c). Pub. L. 91–56, §2(c), substituted ''aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs)'' for ''aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this subchapter)''.

Subsec. (d). Pub. L. 91–56, § 2(d), added subsec. (d).

1968—Subsec. (a)(2). Pub. L. 90–248, § 231, changed the date on which State plans must meet certain financial participation requirements by substituting ''July 1, 1969'' for ''July 1, 1970''.

Subsec. (a)(4). Pub. L. 90–248, § 210(a)(6), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10). Pub. L. 90–248, §§ 223(a), 241(f)(1), struck out ''IV,'' after ''I,'' and inserted '', and part A of subchapter IV of this chapter'' after ''XVI of this chapter'', and designated existing provisions as item I and added item II.

Subsec. (a)(11). Pub. L. 90–248, § 302(b), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(13). Pub. L. 90–248, § 224(a), designated existing provisions as subpar. (A), incorporated existing cl. (A) in provisions designated as subpars. (B) and (C)(i), making subpar. (B) and (C) applicable to individuals receiving aid or assistance under an approved State plan and to individuals not covered under subpar. (B), respectively, added cl. (ii) of subpar. (C), redesignated former cl. (B) as subpar. (D), and deleted effective date of July 1, 1967, for former cls. (A) and (B).

Subsec. (a)(13)(A). Pub. L. 90–248, § 224(c)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(14)(A). Pub. L. 90–248, § 235(a)(1), inserted ''in the case of individuals receiving aid or assistance under State plans approved under subchapters I, X, XIV, XVI, and part A of subchapter IV of this chapter,''.

Subsec. (a)(14)(B). Pub. L. 90–248, § 235(a)(2), inserted ''inpatient hospital services or'' after ''respect to'' and substituted ''to an individual'' for ''him''.

Subsec. (a)(15). Pub. L. 90–248, § 235(a)(3), struck out subpar. (B) provision for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such subchapter, deleted subpar. (B) designation preceding ''where, under the plan'', and substituted therein ''established by such subchapter'' for ''established by part B of such subchapter''.

Subsec. (a)(17). Pub. L. 90–248, § 238, inserted in parenthetical expression ''and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, based on the variations between shelter costs in urban areas and in rural areas'' after ''all groups''.

Pub. L. 90–248, § 241(f)(2), in cl. (B) struck out ''IV,'' after ''I,'' and inserted '', or part A of subchapter IV'' after ''XVI''.

Subsec. (a)(23) to (30). Pub. L. 90–248, §§ 227(a), 228(a), 229(a), 234(a), 236(a), 237, added pars. (23), (24), (25), (26) to (28), (29), (30), respectively.

Subsec. (b)(2). Pub. L. 90–248, § 241(f)(3), inserted ''part A of'' before ''subchapter IV''.

Subsec. (c). Pub. L. 90–248, § 241(f)(4), struck out ''IV,'' after ''I,'' and inserted '', or part A of subchapter IV of this chapter'' after ''XVI of this chapter''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–42, div. G, title I, § 203(b), Mar. 9, 2024, 138 Stat. 403, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on the date that is 24 months after the date of enactment of this Act [Mar. 9, 2024].''

Pub. L. 118–42, div. G, title I, § 205(a)(2), Mar. 9, 2024, 138 Stat. 406, provided that: ''The amendments made by—

''(A) subparagraph (A) of paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Mar. 9, 2024]; and

''(B) subparagraphs (B) through (F) of paragraph (1) [amending this section] shall take effect on January 1, 2026.''

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title V, § 5112(c), Dec. 29, 2022, 136 Stat. 5940, provided that: ''The amendments made by this section [amending this section and section 1397gg of this title] shall take effect on the first day of the first fiscal quarter that begins on or after the date that is 1 year after the date of enactment of this Act [Dec. 29, 2022].''

Pub. L. 117–328, div. FF, title V, § 5121(d), Dec. 29, 2022, 136 Stat. 5943, provided that: ''The amendments made by this section [amending this section and sections 1396d, 1397bb, and 1397jj of this title] shall apply beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after the date of enactment of this Act [Dec. 29, 2022].''

Pub. L. 117–328, div. FF, title V, § 5122(c), Dec. 29, 2022, 136 Stat. 5944, provided that: ''The amendments made by this section [amending this section and sections 1396d and 1397jj of this title] shall take effect on the first day of the first calendar quarter that begins after the date that is 24 months after the date of enactment of this Act [Dec. 29, 2022] and shall apply to items and services furnished for periods beginning on or after such date.''

Pub. L. 117–328, div. FF, title V, § 5123(d), Dec. 29, 2022, 136 Stat. 5946, provided that: ''The amendments made by this section [amending this section and sections 1396u–2 and 1397gg of this title] shall take effect on July 1, 2025.''

Pub. L. 117–328, div. FF, title V, § 5131(c), Dec. 29, 2022, 136 Stat. 5953, provided that: ''The amendments made by this section [amending this section and provisions set out as a note under section 1396d of this title] take effect on April 1, 2023.''

Pub. L. 117–169, title I, § 11405(c), Aug. 16, 2022, 136 Stat. 1901, provided that: ''The amendments made by this section [amending this section and sections 1396d, 1396*o*, 1396*o*–1, and 1397cc of this title] take effect on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after the date of enactment of this Act [Aug. 16, 2022] and shall apply to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act (42 U.S.C. 1396 through 1396w–6) or under a State child health plan or waiver of such plan under title XXI of such Act (42 U.S.C. 1397aa through 1397mm) on or after such effective date.''

Pub. L. 117–103, div. P, title II, § 202(b), Mar. 15, 2022, 136 Stat. 804, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply beginning on January 1, 2024.

''(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] that 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 under this section, 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 [Mar. 15, 2022]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–2, title IX, § 9812(b), Mar. 11, 2021, 135 Stat. 213, as amended by Pub. L. 117–328, div. FF, title V, § 5113, Dec. 29, 2022, 136 Stat. 5940, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to State elections made under paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)), as added by subsection

(a), beginning on the 1st day of the 1st fiscal year quarter that begins one year after the date of the enactment of this Act [Mar. 11, 2021].''

[Pub. L. 117–328, div. FF, title V, §5113, Dec. 29, 2022, 136 Stat. 5940, provided in part that the amendment made by section 5113 to section 9812(b) of Pub. L. 117–2, set out above, is effective as if included in the enactment of Pub. L. 117–2.]

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title II, §209(a)(4), Dec. 27, 2020, 134 Stat. 2986, provided that: ''The amendments made by this subsection [amending this section and sections 1396b and 1396u–7 of this title] shall take effect on the date of the enactment of this Act [Dec. 27, 2020] and shall apply to transportation furnished on or after such date.''

Pub. L. 116–260, div. CC, title II, §209(b)(4)(B), Dec. 27, 2020, 134 Stat. 2988, provided that:

''(i) IN GENERAL.—Except as provided in clause (ii), the amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 27, 2020] and shall apply to services furnished on or after the date that is one year after the date of the enactment of this Act.

''(ii) EXCEPTION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or waiver of such plan, that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section [amending this section and sections 1396b and 1396u–7 of this title], the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an 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. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.''

Amendment by section 210(b) of Pub. L. 116–260 applicable with respect to items and services furnished on or after Jan. 1, 2022, see section 210(e) of Pub. L. 116–260, set out as a note under section 1308 of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–16, §7(b), Apr. 18, 2019, 133 Stat. 864, provided that: ''The amendment made by this section [amending section 202(a)(2) of Pub. L. 113–67, which amended this section] shall take effect on the date of the enactment of this Act [Apr. 18, 2019].''

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1001(d), Oct. 24, 2018, 132 Stat. 3902, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) [amending this section] shall apply to eligibility of juveniles who become inmates of public institutions on or after the date that is 1 year after the date of the enactment of this Act [Oct. 24, 2018].

''(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements 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 these additional requirements 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. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 115–271, title I, §1002(a)(2), Oct. 24, 2018, 132 Stat. 3902, provided that: ''The amendments made by this subsection [amending this section] shall take effect with respect to foster youth who attain 18 years of age on or after January 1, 2023.''

Pub. L. 115–271, title I, §1006(b)(4), Oct. 24, 2018, 132 Stat. 3915, as amended by Pub. L. 118–42, div. G, title I, §201(b), Mar. 9, 2024, 138 Stat. 399, provided that:

''(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection [amending this section and section 1396d of this title] shall apply with respect to medical assistance provided on or after October 1, 2020.

''(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by the amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an 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 [Oct. 24, 2018]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.''

Pub. L. 115–271, title I, §1007(c), Oct. 24, 2018, 132 Stat. 3916, provided that: ''The amendments made by this section [amending this section] take effect on the date of enactment of this Act [Oct. 24, 2018] and shall apply to medical assistance furnished on or after that date, without regard to final regulations to carry out such amendments being promulgated as of such date.''

Pub. L. 115–123, div. E, title XII, §53102(a)(2), Feb. 9, 2018, 132 Stat. 298, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on the date of enactment of this Act [Feb. 9, 2018].''

Pub. L. 115–123, div. E, title XII, §53102(b)(1), Feb. 9, 2018, 132 Stat. 298, provided that, effective Sept. 30, 2017, section 202(b) of Pub. L. 113–67 (amending this section and sections 1396k and 1396p of this title) is repealed and the provisions amended by such subsection shall be applied and administered as if such amendments had never been enacted.

Pub. L. 115–123, div. E, title XII, §53102(b)(3), Feb. 9, 2018, 132 Stat. 299, provided that: ''The repeal and amendment made by this subsection [amending this section, sections 1396k and 1396p of this title, and section 202(c) of Pub. L. 113–67, set out as an Effective Date of 2013 Amendment note below] shall take effect as if enacted on September 30, 2017, and shall apply with respect to any open claims, including claims pending, generated, or filed, after such date. The amendments made by subsections (a) and (b) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note [sic]) [amending this section and sections 1396k and 1396p of this title] that took effect on October 1, 2017, are null and void and section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) shall be applied and administered as if such amendments had not taken effect on such date.''

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that the repeal of section 3(e) of Pub. L. 111–255 is effective as if included in the enactment of Pub. L. 111–255.

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 113–67, div. A, title II, §202(c), Dec. 26, 2013, 127 Stat. 1177, as amended by Pub. L. 113–93, title II, §211, Apr. 1, 2014, 128 Stat. 1047; Pub. L. 114–10, title II, §220,

Apr. 16, 2015, 129 Stat. 154; Pub. L. 115–123, div. E, title XII, § 53102(b)(2), Feb. 9, 2018, 132 Stat. 299, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2019.''

[Pub. L. 113–93, title II, § 211, Apr. 1, 2014, 128 Stat. 1047, provided in part that the amendment made by that section to section 202(c) of Pub. L. 113–67, set out above, is effective as if included in the enactment of Pub. L. 113–67.]

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–296, title I, § 103(c)(2), Dec. 13, 2010, 124 Stat. 3192, provided that:

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall take effect on the date of enactment of this Act [Dec. 13, 2010].

''(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section [amending this section, section 1758 of this title, and section 1232g of Title 20, Education], the State plan shall not be regarded as failing to comply with the requirements of the amendments made by this section solely on the basis of its failure to meet such additional requirements 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 [Dec. 13, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.''

Amendment by Pub. L. 111–255 effective on the earlier of the effective date of final regulations promulgated by the Commissioner of Social Security to carry out such amendment or 180 days after Oct. 5, 2010, see section 3(d) of Pub. L. 111–255, set out as an Effective and Termination Dates of 2010 Amendment note under section 1382a of this title.

Pub. L. 111–148, title II, § 2002(c), Mar. 23, 2010, 124 Stat. 282, provided that: ''The amendments made by subsections (a) and (b) [amending this section] take effect on January 1, 2014.''

Pub. L. 111–148, title II, § 2004(d), title X, § 10201(a)(3), Mar. 23, 2010, 124 Stat. 283, 918, provided that: ''The amendments made by this section [amending this section and sections 1396b, 1396r–1, and 1396u–7 of this title] take effect on January 1, 2014.''

Pub. L. 111–148, title II, § 2202(c), Mar. 23, 2010, 124 Stat. 292, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] take effect on January 1, 2014, and apply to services furnished on or after that date.''

Pub. L. 111–148, title II, § 2301(c), Mar. 23, 2010, 124 Stat. 293, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396d of this title] shall take effect on the date of the enactment of this Act [Mar. 23, 2010] and shall apply to services furnished on or after such date.

''(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 this section, 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 [Mar. 23, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 111–148, title II, § 2303(d), Mar. 23, 2010, 124 Stat. 296, provided that: ''The amendments made by this section [enacting section 1396r–1c of this title and amending this section and sections 1396b, 1396d, and 1396u–7 of this title] take effect on the date of the enactment of this Act [Mar. 23, 2010] and shall apply to items and services furnished on or after such date.''

Pub. L. 111–148, title II, § 2402(g), Mar. 23, 2010, 124 Stat. 304, provided that: ''The amendments made by subsections (b) through (f) [amending this section and sections 1396b, 1396d and 1396n of this title] take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act [Mar. 23, 2010].''

Pub. L. 111–148, title VI, § 6508, Mar. 23, 2010, 124 Stat. 778, provided that:

''(a) IN GENERAL.—Except as otherwise provided in this subtitle [subtitle F (§§ 6501–6508) of title VI of Pub. L. 111–148, amending this section and section 1396b of this title], this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

''(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or a child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] 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 this subtitle, the State plan or child health 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 [Mar. 23, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Amendment by section 8002(a)(2), (b) of Pub. L. 111–148 effective Jan. 1, 2011, see section 8002(e) of Pub. L. 111–148, formerly set out as an Effective Date note under section 300*ll* of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, § 5004(a)(2), Feb. 17, 2009, 123 Stat. 504, provided that: ''The amendments made by this subsection [amending this section and section 1396r–6 of this title] shall take effect on July 1, 2009.''

Pub. L. 111–5, div. B, title V, § 5006(f), Feb. 17, 2009, 123 Stat. 511, provided that: ''The amendments made by this section [amending this section and sections 1396*o*, 1396*o*–1, 1396p, 1396u–2, and 1397gg of this title] shall take effect on July 1, 2009.''

Amendment by section 113(b)(1) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title II, § 203(f), Feb. 4, 2009, 123 Stat. 49, provided that: ''The amendments made by this section [enacting section 1396w–2 of this title and amending this section and section 1397gg of this title] are effective on the date of the enactment of this Act [Feb. 4, 2009].''

Pub. L. 111–3, title II, § 211(d), Feb. 4, 2009, 123 Stat. 54, provided that:

''(1) IN GENERAL.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section

[amending this section and sections 1396b and 1397ee of this title] shall take effect on January 1, 2010.

''(B) TECHNICAL AMENDMENTS.—The amendments made by—

''(i) paragraphs (1), (2), and (3) of subsection (b) [amending this section and section 1396b of this title] shall take effect as if included in the enactment of section 6036 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 80); and

''(ii) paragraph (4) of subsection (b) [amending section 1396b of this title] shall take effect as if included in the enactment of section 405 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2996).

''(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on October 1, 2009, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act [42 U.S.C. 1396b(i)(22), (x)] (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsection (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

''(3) SPECIAL TRANSITION RULE FOR INDIANS.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by subsection (b)(1)(B)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.''

[For definition of ''Medicaid'', see section 1(c)(2) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

Pub. L. 111–3, title V, §501(d)(3), Feb. 4, 2009, 123 Stat. 87, provided that: ''The amendments made by this subsection [amending this section and section 1397gg of this title] shall take effect on January 1, 2009.''

Pub. L. 111–3, title V, §501(e)(3), Feb. 4, 2009, 123 Stat. 88, provided that: ''The amendments made by this subsection [amending this section and section 1397hh of this title] shall be effective for annual reports submitted for years beginning after date of enactment [Feb. 4, 2009].''

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–90, §3(c), Sept. 29, 2007, 121 Stat. 985, provided that: ''The amendments made by this section [amending this section and section 1396u–3 of this title] shall be effective as of September 30, 2007.''

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title VI, §6032(b), Feb. 8, 2006, 120 Stat. 74, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: ''Except as provided in section 6034(e) [set out below], the amendments made by subsection (a) [amending this section] take effect on January 1, 2007.''

Pub. L. 109–171, title VI, §6034(e), Feb. 8, 2006, 120 Stat. 78, provided that: ''Except as otherwise provided in this chapter [chapter 3 (§§6031–6036) of subtitle A of title VI of Pub. L. 109–171, enacting sections 1396h and 1396u–6 of this title, amending this section and sections 1395i, 1395ddd, 1396b, and 1396v of this title, and enacting provisions set out as notes under this section and sections 1396b and 1396h of this title], in the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act [42 U.S.C. 301 et seq.] solely on the basis of its failure to meet these additional requirements 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 [Feb. 8, 2006]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.''

Pub. L. 109–171, title VI, §6035(c), Feb. 8, 2006, 120 Stat. 80, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: ''Except as provided in section 6034(e) [set out above], the amendments made by this section [amending this section] take effect on January 1, 2006.''

Pub. L. 109–171, title VI, §6062(d), Feb. 8, 2006, 120 Stat. 99, provided that: ''The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396*o* of this title] shall apply to medical assistance for items and services furnished on or after January 1, 2007.''

Pub. L. 109–171, title VI, §6065(b), Feb. 8, 2006, 120 Stat. 102, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to medical assistance for items and services furnished on or after the date that is 1 year after the date of enactment of this Act [Feb. 8, 2006].''

Pub. L. 109–171, title VI, §6083(b), Feb. 8, 2006, 120 Stat. 121, provided that: ''The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Feb. 8, 2006].''

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–91, title I, §101(c), Oct. 20, 2005, 119 Stat. 2091, provided that: ''The amendments made by this section [amending this section and section 1396u–3 of this title] shall be effective as of September 30, 2005.''

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–265 effective July 1, 2005, see section 502(b)(4) of Pub. L. 108–265, as amended, set out as an Effective Date note under section 1754 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §103(f)(3), Dec. 8, 2003, 117 Stat. 2160, provided that: ''The amendments made by this subsection [amending this section and section 1396u–3 of this title] shall apply to calendar quarters beginning on or after April 1, 2004.''

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

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–121, §2(c), Jan. 15, 2002, 115 Stat. 2384, provided that:

''(1) BCCPTA TECHNICAL AMENDMENT.—The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106–354; 114 Stat. 1381).

''(2) BIPA TECHNICAL AMENDMENTS.—The amendments made by subsection (b) [amending this section and section 1396n of this title] shall take effect as if included in the enactment of section 702 of the Medicare, Med-

icaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–572) (as enacted into law by section 1(a)(6) of Public Law 106–554).''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §702(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, provided that: ''The amendments made by this section [amending this section and sections 1396b and 1396n of this title and repealing provisions set out as a note under this section] take effect on January 1, 2001, and shall apply to services furnished on or after such date.''

Pub. L. 106–354, §2(d), Oct. 24, 2000, 114 Stat. 1384, provided that: ''The amendments made by this section [enacting section 1396r–1b of this title and amending this section and sections 1396b and 1396d of this title] apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title II, §201(d), Dec. 17, 1999, 113 Stat. 1894, provided that: ''The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396*o* of this title and enacting provisions set out as a note below] apply to medical assistance for items and services furnished on or after October 1, 2000.''

Pub. L. 106–169, title II, §121(b), Dec. 14, 1999, 113 Stat. 1830, provided that: ''The amendments made by subsection (a) [amending this section and section 1396d of this title] apply to medical assistance for items and services furnished on or after October 1, 1999.''

Amendment by section 205(c) of Pub. L. 106–169 effective Jan. 1, 2000, and applicable to trusts established on or after such date, see section 205(d) of Pub. L. 106–169, set out as a note under section 1382a of this title.

Amendment by section 206(b) of Pub. L. 106–169 effective with respect to disposals made on or after Dec. 14, 1999, see section 206(c) of Pub. L. 106–169, set out as a note under section 1382b of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(a)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, provided that: ''The amendments made by this subsection [amending this section and provisions set out as a note under this section] shall take effect as if included in the enactment of section 4712 of BBA (111 Stat. 508) [the Balanced Budget Act of 1997, Pub. L. 105–33].''

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §604(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, provided that:

''(1) The amendment made by subsection (a)(1) [amending this section] applies to expenditures made on and after the date of the enactment of this Act [Nov. 29, 1999].

''(2) The amendments made by subsections (a)(2) and (b) [amending this section and section 1396b of this title] apply as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1932(c)(2) of the Social Security Act (42 U.S.C. 1396u–2(c)(2)).''

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)(1)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(bb)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that: ''Except as otherwise provided, the amendments made by this section [amending this section and sections 1396b, 1396d, 1396g–1, 1396i, 1396n, 1396r, 1396r–1, 1396r–1a, 1396r–4, 1396r–6, 1396r–8, 1396t, 1396u–2, and 1396u–3 of this title] shall take effect on the date of enactment of this Act [Nov. 29, 1999].''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Amendment by section 4454(b)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

Amendment by section 4701(b)(2)(A)(i)–(iv), (d)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on Oct. 1, 1997, except as otherwise provided, see section 4710(a) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4702(b)(2) 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 4709 of Pub. L. 105–33 effective 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)(7) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Pub. L. 105–33, title IV, §4711(d), Aug. 5, 1997, 111 Stat. 508, provided that: ''This section [amending this section and sections 1396d and 1396r–4 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and the amendments made by subsections (a) and (c) [amending this section and sections 1396d and 1396r–4 of this title] shall apply to payment for items and services furnished on or after October 1, 1997.''

Pub. L. 105–33, title IV, §4712(b)(3), Aug. 5, 1997, 111 Stat. 509, provided that: ''The amendments made by this subsection [amending this section and section 1396b of this title] shall apply to services furnished on or after October 1, 1997.''

Pub. L. 105–33, title IV, §4712(c), Aug. 5, 1997, 111 Stat. 509, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, which provided that the amendment made by section 4712(c) was effective for services furnished on or after Oct. 1, 2004, was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, effective Jan. 1, 2001, and applicable to services furnished on or after such date.

Pub. L. 105–33, title IV, §4714(c), Aug. 5, 1997, 111 Stat. 510, provided that: ''The amendments made by this section [amending this section and sections 1395w–4, 1395cc, 1396d of this title] shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]. The amendments made by subsection (a) [amending this section and section 1396d of this title] shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act [42 U.S.C. 1396a(n), 1396d(p)] and that is pending as of, or is initiated after, the date of the enactment of this Act.''

Pub. L. 105–33, title IV, §4715(b), Aug. 5, 1997, 111 Stat. 511, provided that: ''The amendments made by this section [amending this section] shall apply on and after October 1, 1997.''

Pub. L. 105–33, title IV, §4724(c)(2), Aug. 5, 1997, 111 Stat. 517, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 1998.''

Pub. L. 105–33, title IV, §4724(g)(2), Aug. 5, 1997, 111 Stat. 518, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4731(c), Aug. 5, 1997, 111 Stat. 520, provided that: ''The amendments made by this sec-

tion [amending this section] shall apply to medical assistance for items and services furnished on or after October 1, 1997.''

Pub. L. 105–33, title IV, § 4741(c), Aug. 5, 1997, 111 Stat. 523, provided that: ''The amendments made by this section [amending this section and section 1396e of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, § 4751(c), Aug. 5, 1997, 111 Stat. 524, provided that: ''The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, § 4752(b), Aug. 5, 1997, 111 Stat. 525, provided that: ''The amendment made by subsection (a) [amending this section] takes effect on the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, § 4753(c), Aug. 5, 1997, 111 Stat. 526, provided that: ''Except as otherwise specifically provided, the amendments made by this section [amending this section and section 1396b of this title] shall take effect on January 1, 1998.''

Pub. L. 105–33, title IV, § 4911(c), Aug. 5, 1997, 111 Stat. 571, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall apply to medical assistance for items and services furnished on or after October 1, 1997.''

Pub. L. 105–33, title IV, § 4912(c), Aug. 5, 1997, 111 Stat. 573, provided that: ''The amendments made by this section [enacting section 1396r–1a and amending this section and section 1396b of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, § 4913(b), Aug. 5, 1997, 111 Stat. 573, provided that: ''The amendment made by subsection (a) [amending this section] applies to medical assistance furnished on or after July 1, 1997.''

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–248, § 1(a)(2), Oct. 9, 1996, 110 Stat. 3148, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of the amendments made by section 4752(c)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508].''

Amendment by sections 108(k) and 114(b)–(d)(1), of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Pub. L. 104–193, title IX, § 913, Aug. 22, 1996, 110 Stat. 2354, provided that the amendment made by that section is effective Jan. 1, 1997.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–448 effective Oct. 1, 1994, see section 401 of Pub. L. 103–448, set out as a note under section 1755 of this title.

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 13581(b)(2) of Pub. L. 103–66 effective Jan. 1, 1994, see section 13581(d) of Pub. L. 103–66, set out as a note under section 1395y of this title.

Pub. L. 103–66, title XIII, § 13601(c), Aug. 10, 1993, 107 Stat. 613, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1396d of this title] shall take effect as if included in the enactment of section 4721(a) of OBRA–1990 [Pub. L. 101–508].''

Amendment by section 13602(c) of Pub. L. 103–66 applicable to calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not regulations to carry out the amendments by section 13602(a)(1) and (c) of Pub. L. 103–66 have been promulgated by such date, see section 13602(d)(2) of Pub. L. 103–66, set out as a note under section 1396r–8 of this title.

Pub. L. 103–66, title XIII, § 13603(f), Aug. 10, 1993, 107 Stat. 621, provided that: ''The amendments made by this section [amending this section and sections 1396d and 1396n of this title] shall apply to medical assistance furnished on or after January 1, 1994, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Amendment by section 13611(d)(1) of Pub. L. 103–66 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13611 of Pub. L. 103–66 have been promulgated by such date, see section 13611(e) of Pub. L. 103–66, set out as a note under section 1396p of this title.

Pub. L. 103–66, title XIII, § 13622(d), Aug. 10, 1993, 107 Stat. 632, provided that:

''(1) Except as provided in paragraph (2), the amendments made by subsections (a)(1), (b), and (c) [amending this section] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments 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 [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amendments made by subsections (a) and (b) [amending this section and section 1396b of this title], 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 these additional requirements 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 [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(3) The amendment made by subsection (a)(2) [amending section 1396b of this title] shall apply to items and services furnished on or after October 1, 1993.''

Amendment by section 13623(a) of Pub. L. 103–66 applicable, except as otherwise provided, to calendar quarters beginning on or after Apr. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13623 of Pub. L. 103–66 have been promulgated by such date, see section 13623(c) of Pub. L. 103–66, set out as an Effective Date note under section 1396g–1 of this title.

Pub. L. 103–66, title XIII, § 13625(b), Aug. 10, 1993, 107 Stat. 636, provided that: ''Section 1902(a)(61) of the Social Security Act [42 U.S.C. 1396a(a)(61)] (as added by subsection (a)) shall take effect January 1, 1995, and the standards referred to in such section shall be established not later than March 31, 1994.''

Pub. L. 103–66, title XIII, § 13631(e)(2), Aug. 10, 1993, 107 Stat. 644, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Aug. 10, 1993].''

Pub. L. 103–66, title XIII, § 13631(f)(3), Aug. 10, 1993, 107 Stat. 644, provided that:

''(A) Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and section 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amendments made by this subsection, 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 these additional requirements 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 [Aug. 10, 1993]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 103–66, title XIII, § 13631(i), Aug. 10, 1993, 107 Stat. 645, provided that: ''Except as otherwise provided in this section, the amendments made by this section [enacting section 1396s of this title, transferring former section 1396s of this title to section 1396v of this title, and amending this section and sections 1396b and 1396d of this title] shall apply to payments under State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1994.''

EFFECTIVE DATE OF 1991 AMENDMENT

Pub. L. 102–234, § 2(c)(1), Dec. 12, 1991, 105 Stat. 1799, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date.''

Pub. L. 102–234, § 3(e)(1), Dec. 12, 1991, 105 Stat. 1803, provided that: ''The amendments made by this section [amending this section and sections 1396b and 1396r–4 of this title] shall take effect January 1, 1992.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4402(e), Nov. 5, 1990, 104 Stat. 1388–164, provided that:

''(1) The amendments made by this section [enacting section 1396e of this title and amending this section and sections 1396b and 1396d of this title] apply (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, 1991, without regard to whether or not final regulations to carry out such amendments 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 authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a) [enacting section 1396e of this title and amending this section], 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 [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 101–508, title IV, § 4501(f), Nov. 5, 1990, 104 Stat. 1388–166, provided that: ''The amendments made by this section [amending this section and sections 1395v and 1396d of this title] shall apply to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendments are promulgated by such date; except that the amendments made by subsection (e) [amending this section and section 1396d of this title] shall apply to determinations of income for months beginning with January 1991.''

Pub. L. 101–508, title IV, § 4601(b), Nov. 5, 1990, 104 Stat. 1388–167, provided that:

''(1) The amendments made by this subsection [probably should be ''section'', which amended this section and sections 1396b, 1396d, and 1396r–6 of this title] apply (except as otherwise provided in this subsection) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments 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 authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection [section], 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 these additional requirements 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 [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 101–508, title IV, § 4602(b), Nov. 5, 1990, 104 Stat. 1388–167, provided that: ''The amendments made by subsection (a) [amending this section] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calenar [sic] quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 101–508, title IV, § 4603(b), Nov. 5, 1990, 104 Stat. 1388–168, provided that:

''(1) INFANTS.—The amendment made by subsection (a)(1) [amending this section] shall apply to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

''(2) PREGNANT WOMEN.—The amendments made by subsection (a)(2) [amending this section] shall apply with respect to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 101–508, title IV, § 4604(d), Nov. 5, 1990, 104 Stat. 1388–169, provided that:

''(1) The amendments made by this subsection [probably should be ''section'', which amended this section and section 1396n of this title] shall become effective with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments 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 authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection [section], 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 these additional requirements be-

fore 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 [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Amendment by section 4701(b)(1) of Pub. L. 101–508 effective Jan. 1, 1991, see section 4701(c) of Pub. L. 101–508, set out as a note under section 1396b of this title.

Pub. L. 101–508, title IV, §4704(f), Nov. 5, 1990, 104 Stat. 1388–172, provided that: ''The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396n of this title] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

Pub. L. 101–508, title IV, §4708(b), Nov. 5, 1990, 104 Stat. 1388–174, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4711(e), Nov. 5, 1990, 104 Stat. 1388–187, provided that:

''(1) Except as provided in this subsection, the amendments made by this section [enacting section 1396t of this title and amending this section and sections 1396b and 1396d of this title] shall apply to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2)(A) The amendments made by subsection (c)(1) [amending this section] shall apply to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under section 1929(k)(1) [42 U.S.C. 1396t(k)(1)].

''(B) The amendment made by subsection (c)(2) [amending section 1396b of this title] shall apply to civil money penalties imposed after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4713(c), Nov. 5, 1990, 104 Stat. 1388–191, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall apply to medical assistance furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4715(b), Nov. 5, 1990, 104 Stat. 1388–192, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to treatment of income for months beginning more than 30 days after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4732(e), Nov. 5, 1990, 104 Stat. 1388–196, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4751(c), Nov. 5, 1990, 104 Stat. 1388–205, provided that: ''The amendments made by this section [amending this section and sections 1396b and 1396r of this title] shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4752(c)(2), Nov. 5, 1990, 104 Stat. 1388–207, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to medical assistance for calendar quarters beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)].''

Pub. L. 101–508, title IV, §4754(b), Nov. 5, 1990, 104 Stat. 1388–209, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to sanctions effected more than 60 days after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4755(c)(1), Nov. 5, 1990, 104 Stat. 1388–210, provided that the amendment made by that section is effective July 1, 1990.

Pub. L. 101–508, title IV, §4801(e)(11), Nov. 5, 1990, 104 Stat. 1388–217, provided that the amendment made by that section is effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title.

Pub. L. 101–508, title IV, §4801(e)(19), Nov. 5, 1990, 104 Stat. 1388–219, provided that: ''Except as provided in paragraphs (7), (11), and (16), the amendments made by this subsection [amending this section and sections 1396b and 1396r of this title, repealing section 1396g of this title, and amending provisions set out as a note under this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Pub. L. 101–239, title VI, §6401(c), Dec. 19, 1989, 103 Stat. 2259, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after April 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments 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 requirements imposed by the amendments made by this section, 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 these additional requirements 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 [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 101–239, title VI, §6402(c), formerly §6402(d), Dec. 19, 1989, 103 Stat. 2261, as renumbered and amended by Pub. L. 101–508, title IV, §4704(e)(2), Nov. 5, 1990, 104 Stat. 1388–172, provided that: ''The amendments made by this section [enacting section 1396r–7 of this title and amending this section] (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act [Dec. 19, 1989].''

Pub. L. 101–239, title VI, §6403(e), Dec. 19, 1989, 103 Stat. 2264, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall take effect on April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 101–239, title VI, §6404(d), Dec. 19, 1989, 103 Stat. 2264, provided that:

''(1) The amendments made by this section [amending this section and section 1396d of this title] apply (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 April 1, 1990, without regard to whether or not final regulations to carry out such amendments 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 requirements imposed by the amendments made by this section, 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 these additional requirements 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 [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 101–239, title VI, § 6405(c), Dec. 19, 1989, 103 Stat. 2265, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall become effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.''

Pub. L. 101–239, title VI, § 6406(b), Dec. 19, 1989, 103 Stat. 2266, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on July 1, 1990, without regard to whether regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 101–239, title VI, § 6408(c)(2), Dec. 19, 1989, 103 Stat. 2268, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement such amendments.''

Pub. L. 101–239, title VI, § 6408(d)(5), Dec. 19, 1989, 103 Stat. 2269, provided that:

''(A) The amendments made by this subsection [amending this section and sections 1396d and 1396*o* of this title] apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such 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 requirements imposed by the amendments made by this subsection, 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 these additional requirements 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 [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 101–239, title VI, § 6411(a)(2), Dec. 19, 1989, 103 Stat. 2270, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply as if it had been included in the enactment of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360].''

Amendment by section 6411(d)(3)(B) of Pub. L. 101–239 applicable to employment and contracts as of 90 days after Dec. 19, 1989, see section 6411(d)(4)(B) of Pub. L. 101–239, set out as a note under section 1395mm of this title.

Pub. L. 101–239, title VI, § 6411(e)(4), Dec. 19, 1989, 103 Stat. 2272, provided that:

''(A) SPOUSAL TRANSFERS.—The amendments made by paragraph (1) [amending section 1396p of this title] shall apply to transfers occurring after the date of the enactment of this Act [Dec. 19, 1989].

''(B) OTHER AMENDMENTS.—Except as provided in subparagraph (A), the amendments made by this subsection [amending this section and sections 1396p and 1396r–5 of this title] shall apply as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360].''

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 AMENDMENT

Pub. L. 100–647, title VIII, § 8434(c), Nov. 10, 1988, 102 Stat. 3805, provided that: ''The amendment made by this section [amending this section and section 1396d of this title] shall be effective as if included in the enactment of section 301 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360].''

Amendment by section 202(c)(4) of Pub. L. 100–485 effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485 at such earlier effective dates, see section 204(a), (b)(1)(A) of Pub. L. 100–485, set out as a note under section 671 of this title.

Pub. L. 100–485, title III, § 303(f), Oct. 13, 1988, 102 Stat. 2393, as amended by Pub. L. 101–239, title VI, § 6411(i)(2), Dec. 19, 1989, 103 Stat. 2273; Pub. L. 104–193, title I, § 110(q), Aug. 22, 1996, 110 Stat. 2175, provided that:

''(1) The amendments made by this section [enacting section 1396r–6 of this title, amending this section and section 1396d of this title] (other than subsections (b)(3), (d), and (e) [amending this section and section 602 of this title and provisions formerly set out as a note under section 606 of this title]) shall apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement such amendments are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] on or after such date.

''(2) The amendment made by subsection (b)(3) [amending section 602 of this title] shall become effective on April 1, 1990, but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date.

''(3) The amendment made by subsection (d) [amending this section] shall become effective on the effective date of section 402(a)(43) of the Social Security Act, as inserted by section 403(a) of this Act [the first day of the first calendar quarter to begin one year or more after Oct. 13, 1988, see section 403(b) of Pub. L. 100–485, 102 Stat. 2398].

''(4) The amendment made by subsection (e) [amending provisions formerly set out as a note under section 606 of this title] shall take effect on October 1, 1988.''

Pub. L. 100–485, title IV, § 401(g), Oct. 13, 1988, 102 Stat. 2396, as amended by Pub. L. 103–432, title II, § 234(a), Oct. 31, 1994, 108 Stat. 4466, provided that:

''(1) Except as provided in paragraph (2), and in section 1905(m)(2) of the Social Security Act [42 U.S.C. 1396d(m)(2)] (as added by subsection (d)(2) of this section), the amendments made by this section [amending this section and sections 602, 607, and 1396d of this title] shall become effective on October 1, 1990.

''(2) The amendments made by this section shall not become effective with respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, until the date of the repeal of the limitations contained in section 1108(a) of the Social Security Act [42 U.S.C. 1308(a)] on payments to such jurisdictions for purposes of making maintenance payments under parts A and E of title IV of such Act [42 U.S.C. 601 et seq., 670 et seq.].''

[Pub. L. 103–432, title II, § 234(b), Oct. 31, 1994, 108 Stat. 4466, provided that: ''The amendment made by subsection (a) [amending section 401(g)(2) of Pub. L. 100–485, set out above] shall take effect as if included in the provision of the Family Support Act of 1988 [Pub. L. 100–485] to which the amendment relates at the time such provision became law.'']

Amendment by section 608(d)(14)(I), (15)(A), (B), (16)(C), (27)(F)–(H), (28) 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 sec-

tion 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 301(e)(2) of Pub. L. 100–360 effective July 1, 1989, see section 301(e)(3) of Pub. L. 100–360, set out as a note under section 1395v of this title.

Pub. L. 100–360, title III, § 301(h), July 1, 1988, 102 Stat. 750, as amended by Pub. L. 100–485, title VI, § 608(d)(14)(K), Oct. 13, 1988, 102 Stat. 2416, provided that:

''(1) The amendments made by this section [amending this section and sections 1395v, 1396b, and 1396d of this title] apply (except as provided in subsections (e) and (f) [set out as notes under section 1395v and 1396b of this title] and 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, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

''(A) monthly premiums under title XVIII of such Act [42 U.S.C. 1395 et seq.] for months beginning with January 1989, and

''(B) items and services furnished on and after January 1, 1989.

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amendments made by this section, 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 these additional requirements before the first day of the first calendar quarter beginning after the close of the first session of the State legislature that begins after the date of the enactment of this Act [July 1, 1988]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 100–360, title III, § 302(f), July 1, 1988, 102 Stat. 753, provided that:

''(1) IN GENERAL.—The amendments made by this section [amending this section and sections 1396b and 1396r–4 of this title] apply (except as provided in this subsection) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) [amending section 1396r–4 of this title] shall take effect on the date of the enactment of this Act [July 1, 1988].

''(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amendments made by this section (other than subsection (b)(2)), 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 these additional requirements 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. For purposes of the previous sentence, in the case of a State that has a regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Amendment by section 303(d) of Pub. L. 100–360 effective on and after Apr. 8, 1988, with additional provision for supersedure of certain administrative regulations, see section 303(g)(4) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Amendment by section 303(e)(1), (5) of Pub. L. 100–360 applicable to medical assistance furnished on or after Oct. 1, 1982, see section 303(g)(6) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Subsec. (a)(51)(A), as enacted by section 303(e)(2)–(4) of Pub. L. 100–360, applicable to payments under this subchapter for calendar quarters beginning on or after Sept. 30, 1989, without regard to whether or not final regulations to carry out that paragraph have been promulgated by that date, see section 303(g)(1)(A) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Subsec. (a)(51)(B), as enacted by section 303(e)(2)–(4) of Pub. L. 100–360, applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring State legislative action), without regard to whether or not final regulations to carry out that paragraph have been promulgated by that date, with an exception for resources disposed of before July 1, 1988, see section 303(g)(2)(A), (C), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(5), (7)(B)–(D), (10)(G)(ii), (iv), (17)(B), (*l*)(3)(E), (H), (J), (6)(C), (D), (8)(C), and (n)(2), (4) 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.

EFFECTIVE DATE OF 1987 AMENDMENT

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Pub. L. 100–203, title IV, § 4101(a)(3), Dec. 22, 1987, 101 Stat. 1330–141, provided that: ''The amendments made by this subsection [amending this section] shall apply to medical assistance furnished on or after July 1, 1988.''

Pub. L. 100–203, title IV, § 4101(b)(3), Dec. 22, 1987, 101 Stat. 1330–141, provided that: ''The amendments made by this subsection [amending this section and provisions set out below] shall apply with respect to medical assistance furnished on or after July 1, 1988.''

Amendment by section 4101(c)(2) of Pub. L. 100–203 applicable to medical assistance furnished on or after Oct. 1, 1988, see section 4101(c)(3) of Pub. L. 100–203, set out as a note under section 1396d of this title.

Pub. L. 100–203, title IV, § 4101(e)(6), Dec. 22, 1987, 101 Stat. 1330–143, provided that:

''(A) The amendment made by paragraph (1) [amending this section] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

''(B) The amendments made by paragraphs (2) and (3) [amending this section] shall be effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].

''(C) The amendment made by paragraph (4) [amending this section] shall apply to elections made on or after the enactment of this Act.

''(D) The amendment made by paragraph (5) [amending this section] shall apply as if included in the enactment of section 9401 of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Pub. L. 100–203, title IV, § 4113(c)(3), Dec. 22, 1987, 101 Stat. 1330–152, provided that: ''The amendments made by this subsection [amending this section] shall apply to services furnished on and after July 1, 1988.''

Pub. L. 100–203, title IV, § 4118(c)(2), Dec. 22, 1987, 101 Stat. 1330–155, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective as if it were included in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 [Pub. L. 97–248].''

Pub. L. 100–203, title IV, § 4118(h)(3), formerly § 4118(h)(2), Dec. 22, 1987, 101 Stat. 1330–156, as renumbered and amended by Pub. L. 100–360, title IV, § 411(k)(10)(G)(iii), July 1, 1988, 102 Stat. 796, provided that: ''The amendments made by this subsection [amending this section and section 1396b of this title] shall apply to costs incurred after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, § 4118(m)(2), Dec. 22, 1987, 101 Stat. 1330–157, provided that: ''The amendments made by paragraph (1) [amending this section and repealing section 1320a–8 of this title] shall apply to audits conducted after the date of the enactment of this Act [Dec. 22, 1987].''

Amendments by sections 4211(b)(1), (h)(1)–(5), 4212(d)(2), (3), (e)(1) 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 1396r of this title, and except that subsec. (a)(28)(B) of this section as amended by section 4211(b) of Pub. L. 100–203 applicable to calendar quarters beginning more than 6 months after Dec. 22, 1987, 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.

Pub. L. 100–203, title IV, § 4212(d)(4), Dec. 22, 1987, 101 Stat. 1330–213, provided that: ''The amendments made by this subsection [amending this section and section 1396b of this title] shall not apply to a State until such date (not earlier than October 1, 1990) as of which the Secretary determines that—

''(A) the State has specified the resident assessment instrument under section 1919(e)(5) of the Social Security Act [42 U.S.C. 1396r(e)(5)], and

''(B) the State has begun conducting surveys under section 1919(g)(2) of such Act.''

Amendment by section 4213(b)(1) of Pub. L. 100–203 applicable to payments under this subchapter for calendar quarters beginning on or after Dec. 22, 1987, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(b) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Pub. L. 100–203, title IV, § 4218(b), Dec. 22, 1987, 101 Stat. 1330–221, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990.''

Amendment by section 9115(b) of Pub. L. 100–203 effective July 1, 1988, see section 9115(c) of Pub. L. 100–203, set out as a note under section 1382 of this title.

Pub. L. 100–203, title IX, § 9119(d)(2), as added by Pub. L. 100–360, title IV, § 411(n)(4), formerly § 411(n)(3), July 1, 1988, 102 Stat. 807, and renumbered by Pub. L. 100–485, title VI, § 608(d)(28), Oct. 13, 1988, 102 Stat. 2423, provided that: ''The amendments made by paragraph (1) [amending this section] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Amendment by sections 5(a) and 8(f) of Pub. L. 100–93, applicable, with certain exception, to payments under subchapter XIX of this chapter for calendar quarters beginning more than thirty days after Aug. 18, 1987, without regard to whether or not final regulations to carry out such amendments have been published by such date, see section 15(c) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

Amendment by section 7 of Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–643, § 10(b), Nov. 10, 1986, 100 Stat. 3580, provided that:

''(1) Except as provided in paragraph (2), the amendments made by sections 3, 4, 5, 6, and 7 [amending this section and sections 1382, 1382c, 1382h, 1383, and 1396s of this title] shall become effective on July 1, 1987.

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the requirements imposed by the amendments made by section 3(b) [amending this section] and section 7 of this Act [amending this section and section 1382h of this title], 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 such additional requirements until 60 days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 10, 1986].''

Pub. L. 99–570, title XI, § 11005(c)(2), Oct. 27, 1986, 100 Stat. 3207–169, provided that: ''The amendments made by subsection (b) [amending this section] shall become effective on January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

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 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, § 9401(f), Oct. 21, 1986, 100 Stat. 2052, as amended by Pub. L. 100–203, title IV, § 4101(b)(2)(C), Dec. 22, 1987, 101 Stat. 1330–141, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to medical assistance furnished in calendar quarters beginning on or after April 1, 1987.

''(2) Subparagraph (C) of section 1902(*l*)(1) of the Social Security Act [42 U.S.C. 1396a(*l*)(1)(C)], as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1987.

''(3) An amendment made by this section shall become effective as provided in paragraph (1) or (2) without regard to whether or not final regulations to carry out such amendment have been promulgated by the applicable date.''

Pub. L. 99–509, title IX, § 9402(c), Oct. 21, 1986, 100 Stat. 2053, provided that: ''The amendments made by this section [amending this section] shall apply to payments to States 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.''

Pub. L. 99–509, title IX, § 9403(h), Oct. 21, 1986, 100 Stat. 2056, provided that: ''The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396*o* of this title] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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.''

Pub. L. 99–509, title IX, § 9404(c), Oct. 21, 1986, 100 Stat. 2057, provided that:

''(1) The amendments made by this section [amending this section and section 1396d of this title] apply (ex-

cept 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 July 1, 1987, without regard to whether regulations to implement such amendments are 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 requirements imposed by the amendments made by this section, 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 these additional requirements 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 [Oct. 21, 1986].''

Pub. L. 99–509, title IX, §9406(c), Oct. 21, 1986, 100 Stat. 2058, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to medical assistance furnished to aliens on or after January 1, 1987, without regard to whether or not final regulations to carry out such amendments 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 [42 U.S.C. 1396 et seq.] 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 in subsection (b) [amending this section], 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 such 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 [Oct. 21, 1986].''

Pub. L. 99–509, title IX, §9407(d), Oct. 21, 1986, 100 Stat. 2060, provided that: ''The amendments made by this section [enacting section 1396r–1 of this title and amending this section and sections 1396b and 1396s of this title] shall apply to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 99–509, title IX, §9408(d), Oct. 21, 1986, 100 Stat. 2061, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall apply to services furnished on or after the date of the enactment of this Act [Oct. 21, 1986].''

Pub. L. 99–509, title IX, §9431(c), Oct. 21, 1986, 100 Stat. 2066, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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.''

Pub. L. 99–509, title IX, §9433(b), Oct. 21, 1986, 100 Stat. 2068, provided that: ''The amendment made by subsection (a) [amending section 2173 of Pub. L. 97–35, which amended this section] shall apply as though it was included in the enactment of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35).''

Pub. L. 99–509, title IX, §9435(f), Oct. 21, 1986, 100 Stat. 2071, provided that: ''The amendments made by this section [amending this section and section 1396d of this title and provisions set out as notes under this section and sections 1396d and 1396n of this title] shall be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].''

Pub. L. 99–272, title IX, §9501(d)(2), (3), Apr. 7, 1986, 100 Stat. 202, provided that:

''(2) OPTIONAL SERVICES.—The amendments made by subsection (b) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].

''(3) CONTINUED COVERAGE.—The amendment made by subsection (c) [amending this section] shall apply to medical assistance furnished to a woman on or after the date of the enactment of this Act.''

Pub. L. 99–272, title IX, §9503(g), Apr. 7, 1986, 100 Stat. 207, provided that:

''(1) Except as otherwise provided, the amendments made by this section [amending this section and sections 1396b and 1396k of this title and section 1144 of Title 29, Labor, and enacting provisions set out as notes under this section and section 1144 of Title 29] shall apply to calendar quarters beginning on or after the date of the enactment of this Act [Apr. 7, 1986].

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amendments made by this section, 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 these additional requirements 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.

''(3) No penalty may be applied against any State for a violation of section 1902(a)(25) of the Social Security Act [42 U.S.C. 1396a(a)(25)] occurring prior to the effective date of the amendments made by this section.

''(4) The amendment made by subsection (c) [enacting provisions set out below] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

Pub. L. 99–272, title IX, §9505(e), Apr. 7, 1986, 100 Stat. 209, as amended by Pub. L. 99–509, title IX, §9435(d)(1), Oct. 21, 1986, 100 Stat. 2070, provided that: ''The amendments made by this section [amending this section and sections 1396d and 1396*o* of this title] shall apply to medical assistance provided for hospice care furnished on or after the date of the enactment of this Act [Apr. 7, 1986], without regard to whether or not regulations to carry out the amendments have been promulgated by that date.''

Pub. L. 99–272, title IX, §9506(b), (c), Apr. 7, 1986, 100 Stat. 210, as amended by Pub. L. 99–509, title IX, §9435(c), Oct. 21, 1986, 100 Stat. 2070, provided that:

''(b) EFFECTIVE DATE.—The amendment made by subsection (a) [amending this section] shall apply to medical assistance furnished on or after the first day of the second month beginning after the date of the enactment of this Act [Apr. 7, 1986].

''(c) EXCEPTION.—The amendment made by subsection (a) [amending this section] shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.''

Pub. L. 99–272, title IX, §9509(b), Apr. 7, 1986, 100 Stat. 211, provided that:

''(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section and enacting provisions set out below] shall apply to medical assistance furnished on or after October 1, 1985, but only with respect to changes of ownership occurring on or after such date.

''(2) The amendments made by this section shall not apply with respect to a change of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

''(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amend-

ments made by this section, 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 the requirements imposed by the amendments made by this section 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].''

Pub. L. 99–272, title IX, § 9510(b), Apr. 7, 1986, 100 Stat. 212, 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 with respect to payment for services furnished on or after October 1, 1985, without regard to whether or not regulations to carry out the amendment have been promulgated by that date.''

Pub. L. 99–272, title IX, § 9529(a)(2), Apr. 7, 1986, 100 Stat. 220, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act [Apr. 7, 1986].''

Pub. L. 99–272, title IX, § 9529(b)(3), Apr. 7, 1986, 100 Stat. 221, provided that: ''This subsection, and the amendments made by this subsection [amending this section and enacting provisions set out below], shall apply to adoption assistance agreements entered into before, on, or after the date of the enactment of this Act [Apr. 7, 1986].''

Amendment by section 12305(b)(3) of Pub. L. 99–272 applicable to medical assistance furnished in or after first calendar quarter beginning more than 90 days after Apr. 7, 1986, see section 12305(c) of Pub. L. 99–272, set out as a note under section 673 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(1) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1) and (3) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Pub. L. 98–369, div. B, title III, § 2314(c)(3), July 18, 1984, 98 Stat. 1080, provided that:

''(A) Except as provided in subparagraph (B), the amendments made by subsection (b) [amending this section] shall apply to medical assistance furnished on or after October 1, 1984.

''(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section [amending this section and section 1395x of this title and enacting provisions set out as a note under section 1395x of this title], 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 [July 18, 1984].''

Amendment by section 2335(e) 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.

Pub. L. 98–369, div. B, title III, § 2361(d), July 18, 1984, 98 Stat. 1104, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 606 and 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1984, without regard to whether or not final regulations to carry out such amendments 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 [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, 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 these additional requirements 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 [July 18, 1984].''

Pub. L. 98–369, div. B, title III, § 2362(b), July 18, 1984, 98 Stat. 1105, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to children born on or after October 1, 1984.''

Amendment by section 2363(a)(1) of Pub. L. 98–369 applicable to calendar quarters beginning on or after July 18, 1984, except that, in the case of individuals admitted to skilled nursing facilities before that date, the amendment shall not require recertifications sooner or more frequently than were required under the law in effect before that date, see section 2363(c) of Pub. L. 98–369, set out as a note under section 1396b of this title.

Pub. L. 98–369, div. B, title III, § 2367(c), July 18, 1984, 98 Stat. 1109, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396k of this title] shall become effective on October 1, 1984.

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section, 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 [July 18, 1984].''

Pub. L. 98–369, div. B, title III, § 2368(c), July 18, 1984, 98 Stat. 1110, provided that: ''The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2651(c) of Pub. L. 98–369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(*l*)(2) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 131(a), (c) of Pub. L. 97–248 effective Oct. 1, 1982, see section 131(d) of Pub. L. 97–248, formerly § 131(c), redesignated Pub. L. 97–448, title III, § 309(a)(8), Jan. 12, 1983, 96 Stat. 2408, set out as an Effective Date note under section 1396*o* of this title.

Amendment by section 132(a), (c) of Pub. L. 97–248 effective Sept. 3, 1982, see section 132(d) of Pub. L. 97–248, set out as an Effective Date note under section 1396p of this title.

Pub. L. 97–248, title I, § 134(b), Sept. 3, 1982, 96 Stat. 375, provided that: ''The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1982.''

Amendment by section 136(d) 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.

Pub. L. 97–248, title I, § 137(d), Sept. 3, 1982, 96 Stat. 381, provided that:

''(1) Except as otherwise provided in this section, any amendment to the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35] made by this section [amending this section and sections 1320a–1 and 1396b of this title and provisions set out as a note under section 603 of

this title] shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

''(2) Except as otherwise provided in this section, any amendment to the Social Security Act [42 U.S.C. 301 et seq.] made by the preceding provisions of this section [amending this section and sections 701, 705, 1320a–7a, 1320b–4, 1396b, 1396d, and 1396n of this title] shall be effective as if it had been originally included as a part of that provision of the Social Security Act to which it relates, as such provision of the Social Security Act was amended by the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35].''

Amendment by section 146(a) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2113(*o*), Aug. 13, 1981, 95 Stat. 796, provided that: ''The amendments made by this section [amending this section and sections 1320c, 1320c–1, 1320c–3, 1320c–4, 1320c–7, 1320c–8, 1320c–9, 1320c–11, 1320c–17, 1320c–21, and 1396b of this title and repealing sections 1320c–13 and 1320c–20 of this title] apply to agreements with Professional Standards Review Organizations entered into on or after October 1, 1981.''

Pub. L. 97–35, title XXI, §2171(c), Aug. 13, 1981, 95 Stat. 808, provided that: ''The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [Aug. 13, 1981].''

Pub. L. 97–35, title XXI, §2172(c), Aug. 13, 1981, 95 Stat. 808, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall become effective on the date of the enactment of this Act [Aug. 13, 1981].''

Pub. L. 97–35, title XXI, §2173(b)(2), Aug. 13, 1981, 95 Stat. 809, provided that: ''The amendment made by paragraph (1) [amending this section] shall not apply with respect to services furnished before the date the Secretary of Health and Human Services first promulgates and has in effect final regulations (on an interim or other basis) to carry out section 1902(a)(13)(A) of the Social Security Act [42 U.S.C. 1396a(a)(13)(A)] (as amended by this subtitle).''

Pub. L. 97–35, title XXI, §2174(c), Aug. 13, 1981, 95 Stat. 809, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] shall apply to services furnished on or after October 1, 1981.''

Pub. L. 97–35, title XXI, §2175(d)(2), Aug. 13, 1981, 95 Stat. 811, provided that:

''(A) The amendments made by paragraph (1) [amending this section] shall (except as provided under subparagraph (B)) be effective with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1981.

''(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1)(C), 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 year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 13, 1981].''

Pub. L. 97–35, title XXI, §2178(c), Aug. 13, 1981, 95 Stat. 815, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] shall apply with respect to services furnished, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on or after October 1, 1981; except that such amendments shall not apply with respect to services furnished by a health maintenance organization under a contract with a State entered into under such title before October 1, 1981 unless the organization requests that such amendments apply and the Secretary of Health and Human Services and the single State agency (administering or supervising the administration of the State plan under such title) agree to such request.''

Pub. L. 97–35, title XXI, §2181(b), Aug. 13, 1981, 95 Stat. 815, as amended by Pub. L. 97–248, title I, §137(a)(4), Sept. 3, 1982, 96 Stat. 376, provided that: ''The amendment made by subsection (a)(1) [amending section 603 of this title] shall apply to reductions for calendar quarters beginning on or after June 30, 1974, and the amendments made by subsection (a)(2) [amending this section] shall take effect on October 1, 1981, except that, in the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order to incorporate the provisions required to be included by this section into such State plan, 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 include the provisions required to be included in such State plan by subsection (a)(2) of this section 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 [Aug. 13, 1981], but the requirements previously set forth in paragraphs (1) through (3) of section 403(g) of the Social Security Act [42 U.S.C. 603(g)(1)–(3)] (prior to its repeal by this section) shall apply under title XIX of such Act to such State on and after October 1, 1981, whether or not the provisions required to be included by this section in the State plan under title XIX have been incorporated into such State plan.''

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(9) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 902(b) of Pub. L. 96–499 effective on date on which final regulations to implement the amendment are first issued, see section 902(c) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Pub. L. 96–499, title IX, §914(b)(2), Dec. 5, 1980, 94 Stat. 2622, as amended by Pub. L. 97–248, title I, §137(c)(1), Sept. 3, 1982, 96 Stat. 381, provided that:

''(A) The amendments made by paragraph (1) [amending this section] shall (except as provided under subparagraph (B)) apply to cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].''

''(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), 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 these additional requirements 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.''

Pub. L. 96–499, title IX, §918(b)(2), Dec. 5, 1980, 94 Stat. 2626, provided that:

''(A) The amendments made by paragraph (1) [enacting this section] shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act [Dec. 5, 1980].

''(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 in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), 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 these additional requirements 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.''

Pub. L. 96–499, title IX, § 962(b), Dec. 5, 1980, 94 Stat. 2651, provided that: ''The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1980.''

Pub. L. 96–499, title IX, § 965(c), Dec. 5, 1980, 94 Stat. 2652, provided that:

''(1) The amendments made by this section [amending this section and section 1396d of this title] shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act [Dec. 5, 1980].

''(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 in order for the plan to meet the additional requirements imposed by the amendments made by this section, 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 these additional requirements 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.''

EFFECTIVE DATE OF 1978 AMENDMENT

Pub. L. 95–559, § 14(a)(2), Nov. 1, 1978, 92 Stat. 2140, provided that:

''(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) [amending this section] shall take effect one hundred and eighty days after the date of the enactment of this Act [Nov. 1, 1978].

''(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the requirement added by the amendments made by paragraph (1), such amendments shall not apply with respect to such State plan before ninety days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.''

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.

Amendment by section 2(a)(3) of Pub. L. 95–142 applicable with respect to care and services furnished on or after Oct. 25, 1977, see section 2(a)(4) of Pub. L. 95–142, set out as a note under section 1395g of this title.

Pub. L. 95–142, § 2(b)(2), Oct. 25, 1977, 91 Stat. 1177, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to calendar quarters beginning on and after July 1, 1978, with respect to State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].''

Amendment by section 3(c)(1) of Pub. L. 95–142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Pub. L. 95–142, § 7(e)(2), Oct. 25, 1977, 91 Stat. 1194, provided that: ''The amendment made by subsection (b) [amending this section] shall become effective on January 1, 1978.''

Pub. L. 95–142, § 19(c)(2), Oct. 25, 1977, 91 Stat. 1205, provided that:

''(A) The amendments made by subsection (b) [amending this section and section 1395x of this title] shall apply with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under section 1121(a) of the Social Security Act) [42 U.S.C. 1320a(a)] for that type of health services facility.

''(B) The amendments made by subsection (b) [amending this section and section 1395x of this title] shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare [now Health and Human Services] determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

''(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) [amending this section] shall apply, with respect to State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after October 1, 1977.''

Amendment by section 20(b) of Pub. L. 95–142 effective Oct. 1, 1977, and the Secretary to adjust payments made to States under section 1396b of this title to reflect such amendment, see section 20(c) of Pub. L. 95–142, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–552, § 2, Oct. 18, 1976, 90 Stat. 2540, provided that: ''The amendments made by the first section [amending this section and section 1396b of this title] shall take effect as of January 1, 1976.''

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, § 111(c), Dec. 31, 1975, 89 Stat. 1054, provided that: ''The amendments made by this section [amending this section and section 1396b of this title] shall (except as otherwise provided for therein) become effective January 1, 1976.''

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–368, § 9(b), Aug. 7, 1974, 88 Stat. 422, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective January 1, 1973.''

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, § 13(d), Dec. 31, 1973, 87 Stat. 965, provided that: ''The amendments made by subsection (a) [amending this section and sections 1396, 1396b, and 1396d of this title] shall be effective with respect to payments under section 1903 of the Social Security Act [42 U.S.C. 1396b] for calendar quarters commencing after December 31, 1973.''

Pub. L. 93–233, § 18(z–3)(4), Dec. 31, 1973, 87 Stat. 974, provided that: ''The amendments made by subsections (*o*) and (u) [amending this section and section 1396b of this title] shall be effective July 1, 1973''.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 208(b), Oct. 30, 1972, 86 Stat. 1381, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective January 1, 1973 (or earlier if the State plan so provided).''

Pub. L. 92–603, title II, § 209(b)(2), Oct. 30, 1972, 86 Stat. 1382, provided that: ''The amendment made by this subsection [amending this section] shall become effective on January 1, 1974.''

Pub. L. 92–603, title II, § 232(c), Oct. 30, 1972, 86 Stat. 1411, provided that: ''The amendments made by this

section [amending this section and section 705 of this title] shall be effective July 1, 1972 (or earlier if the State plan so provides).''

Amendment by section 236(b) of Pub. L. 92–603 effective Jan. 1, 1973, or earlier if the State plan so provides, see section 236(c) of Pub. L. 92–603, set out as a note under section 1395u of this title.

Pub. L. 92–603, title II, §237(d)(2), Oct. 30, 1972, 86 Stat. 1416, provided that: ''The amendment made by subsection (a)(2) [amending this section] shall be effective July 1, 1973.''

Pub. L. 92–603, title II, §239(d), Oct. 30, 1972, 86 Stat. 1418, provided that: ''The amendments made by this section [amending this section and section 705 of this title] shall be effective January 1, 1973 (or earlier if the State plan so provides).''

Amendment by section 246(a) of Pub. L. 92–603 to be effective July 1, 1973, see section 246(c) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §255(b), Oct. 30, 1972, 86 Stat. 1446, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective July 1, 1973.''

Pub. L. 92–603, title II, §268(c), Oct. 30, 1972, 86 Stat. 1451, provided that: ''The amendments made by this section [amending this section and section 1396g of this title] shall be effective on the date of the enactment of this Act [Oct. 30, 1972].''

Amendment by section 299D(b) of Pub. L. 92–603 effective beginning Jan. 1, 1973, or within 6 months following Oct. 30, 1972, whichever is later, see section 299D(c) of Pub. L. 92–603, set out as a note under section 1395aa of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–223, §4(d), Dec. 28, 1971, 85 Stat. 810, as amended by Pub. L. 92–603, title II, §292, Oct. 30, 1972, 86 Stat. 1458, provided that: ''The amendments made by this section [amending this section and section 1396d of this title and repealing section 1320a of this title] shall become effective January 1, 1972; except that the repeal made by subsection (c) [repealing section 1320a of this title], shall not become effective in the case of any State, which on January 1, 1972 did not have in effect a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], until the first day of the first month (occurring after such date) that such State does have in effect a State plan approved under such title [42 U.S.C. 1396 et seq.].''

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 210(a)(6) of Pub. L. 90–248 effective July 1, 1969, or, if earlier (with respect to a State's plan approved under this subchapter) on the date as of which the modification of the State plan to comply with such amendment is approved, see section 210(b) of Pub. L. 90–248, set out as a note under section 302 of this title.

Pub. L. 90–248, title II, §223(b), Jan. 2, 1968, 81 Stat. 902, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1967.''

Pub. L. 90–248, title II, §224(b), Jan. 2, 1968, 81 Stat. 902, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after December 31, 1967.''

Pub. L. 90–248, title II, §224(c)(2), Jan. 2, 1968, 81 Stat. 902, provided that: ''The amendment made by paragraph (1) of this subsection [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1970.''

Pub. L. 90–248, title II, §227(b), Jan. 2, 1968, 81 Stat. 904, as amended by Pub. L. 92–603, title II, §271A(a), Oct. 30, 1972, 86 Stat. 1451, provided that: ''The amendments made by this section [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1969; except that such amendments shall apply in the case of Puerto Rico, the Virgin Islands, and Guam only with respect to calendar quarters beginning after June 30, 1975.''

[Pub. L. 92–603, title II, §271A(b), Oct. 30, 1972, 86 Stat. 1451, provided that: ''The amendment made by subsection (a) [amending section 227(b) of Pub. L. 90–248, set out above] shall be effective from and after July 1, 1972.'']

Pub. L. 90–248, title II, §229(b), Jan. 2, 1968, 81 Stat. 904, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to legal liabilities of third parties arising after March 31, 1968.''

Pub. L. 90–248, title II, §234(b), Jan. 2, 1968, 81 Stat. 907, provided that: ''The amendments made by subsection (a) of this section [amending this section] (unless otherwise specified in the body of such amendments) shall take effect on January 1, 1969.''

Pub. L. 90–248, title II, §235(b), Jan. 2, 1968, 81 Stat. 908, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective in the case of calendar quarters beginning after December 31, 1967.''

Enactment by section 236(a) of Pub. L. 90–248 effective July 1, 1970, except as otherwise specified in the text thereof, see section 236(c) of Pub. L. 90–248, set out as an Effective Date note under section 1396g of this title.

Pub. L. 90–248, title II, §237, Jan. 2, 1968, 81 Stat. 911, provided that the amendment made by that section is effective Apr. 1, 1968.

Pub. L. 90–248, title II, §238, Jan. 2, 1968, 81 Stat. 911, provided that the amendment made by that section is effective July 1, 1969.

REGULATIONS

Pub. L. 99–272, title IX, §9503(c), Apr. 7, 1986, 100 Stat. 206, provided that: ''The Secretary of Health and Human Services shall promulgate final regulations necessary to carry out sections 1902(a)(25) and 1903(r)(6)(J) of the Social Security Act [42 U.S.C. 1396a(a)(25), 1396b(r)(6)(J)] within 6 months after the date of the enactment of this Act [Apr. 7, 1986].''

RULE OF CONSTRUCTION RELATED TO INCOME OR RESOURCE DISREGARD METHODOLOGY, OR SPOUSAL INCOME AND ASSET DISREGARD

Pub. L. 116–260, div. CC, title II, §205(b), Dec. 27, 2020, 134 Stat. 2983, provided that: ''Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1902(a)(17) or 1924 of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396r–5) shall be construed as prohibiting a State from—

''(1) applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (42 U.S.C. 1396a(r)(2))—

''(A) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) (including a disregard of the income or resources of such individual's spouse); or

''(B) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315); or

''(2) disregarding an individual's spousal income and assets under a plan amendment to provide medical assistance for home and community-based services for individuals by reason of being determined eligible under section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) or by reason of section 1902(f) of such Act (42 U.S.C. 1396a(f)) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care under which the State disregarded the income and assets of the individual's spouse in determining the initial and ongoing financial eligibility of an individual for such services in place of the spousal impoverishment provisions applied under section 1924 of such Act (42 U.S.C. 1396r–5).''

Similar provisions were contained in the following prior acts:

Pub. L. 116–215, div. B, title I, § 1105(b), Dec. 11, 2020, 134 Stat. 1043.

Pub. L. 116–159, div. C, title III, § 2302(b), Oct. 1, 2020, 134 Stat. 731.

Pub. L. 116–136, div. A, title III, § 3812(b), Mar. 27, 2020, 134 Stat. 429.

Pub. L. 116–94, div. N, title I, § 204(b), Dec. 20, 2019, 133 Stat. 3111.

RULE OF CONSTRUCTION RELATED TO INCOME OR RESOURCE DISREGARD METHODOLOGY

Pub. L. 116–39, § 3(b), Aug. 6, 2019, 133 Stat. 1061, provided that: ''Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1902(a)(17) or 1924 of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396r–5) shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (42 U.S.C. 1396a(r)(2))—

''(1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) (including a disregard of the income or resources of such individual's spouse); or

''(2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315).''

CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title I, § 1001(b), Oct. 24, 2018, 132 Stat. 3901, provided that: ''Nothing in this section [amending this section and enacting provisions set out as notes under this section] shall be construed as changing the exclusion from medical assistance under the subdivision (A) following paragraph (30) [now (32)] of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as redesignated by section 1006(b)(2)(B) of this Act, including any applicable restrictions on a State submitting claims for Federal financial participation under title XIX of such Act [42 U.S.C. 1396 et seq.] for such assistance.''

Pub. L. 115–271, title I, § 1001(c), Oct. 24, 2018, 132 Stat. 3902, provided that: ''Nothing in this section [amending this section and enacting provisions set out as notes under this section] shall be construed to mandate, encourage, or suggest that a State suspend or terminate coverage for individuals before they have been adjudicated or sentenced.''

Pub. L. 115–123, div. E, title XII, § 53103(b), Feb. 9, 2018, 132 Stat. 301, provided that:

''(1) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by subsection (a)(2) [amending this section] shall be construed as preventing a State from intercepting the State lottery winnings awarded to an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for medical assistance furnished to the individual.

''(2) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by subsection (a)(2) shall be construed, with respect to a determination of household income for purposes of a determination of eligibility for medical assistance under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) made by applying modified adjusted gross income under subparagraph (A) of section 1902(e)(14) of such Act (42 U.S.C. 1396a(e)(14)), as limiting the eligibility for such medical assistance of any individual that is a member of the household other than the individual who received qualified lottery winnings or qualified lump-sum income (as defined in subparagraph (K) of such section 1902(e)(14), as added by subsection (a)(2) of this section).''

CONSTRUCTION OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, § 5005(d), Dec. 13, 2016, 130 Stat. 1194, provided that: ''Nothing in this section [amending this section and sections 1396b, 1396u–2, and 1397gg of this title and enacting provisions set out as a note under this section] shall be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act [42 U.S.C. 301 et seq.].''

Pub. L. 114–255, div. A, title V, § 5006(c), Dec. 13, 2016, 130 Stat. 1196, provided that:

''(1) IN GENERAL.—The amendment made by subsection (a) [amending this section] shall not be construed to apply in the case of a State (as defined for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) in which all the individuals enrolled in the State plan under such title (or under a waiver of such plan), other than individuals described in paragraph (2), are enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A))), including prepaid inpatient health plans and prepaid ambulatory health plans (as defined by the Secretary of Health and Human Services).

''(2) INDIVIDUALS DESCRIBED.—An individual described in this paragraph is an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or an Alaska Native.''

CONSTRUCTION OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, § 5006(e)(3), Feb. 17, 2009, 123 Stat. 511, provided that: ''Nothing in the amendments made by this subsection [amending this section and section 1397gg of this title] shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.''

CONSTRUCTION OF 1999 AMENDMENT

Pub. L. 106–169, title I, § 121(c), Dec. 14, 1999, 113 Stat. 1830, provided that: ''If the Ticket to Work and Work Incentives Improvement Act of 1999 [Pub. L. 106–170] is enacted (whether before, on, or after the date of the enactment of this Act)—

''(1) the amendments made by that Act [see Tables for classification] shall be executed as if this Act [see Short Title of 1999 Amendment note under section 1305 of this title] had been enacted after the enactment of such other Act;

''(2) with respect to subsection (a)(1)(A) of this section [amending this section], any reference to subclause (XIII) is deemed a reference to subclause (XV);

''(3) with respect to subsection (a)(1)(B) of this section [amending this section], any reference to subclause (XIV) is deemed a reference to subclause (XVI);

''(4) [Amended this section.]

''(5) [Amended section 1396d of this title.]''

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary of Health and Human Services under subsec. (a)(4)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(3)(D) of this title.

ADDRESSING OPERATIONAL BARRIERS TO PROMOTE CONTINUITY OF CARE FOR MEDICAID AND CHIP BENEFICIARIES FOLLOWING INCARCERATION

Pub. L. 118–42, div. G, title I, § 206, Mar. 9, 2024, 138 Stat. 406, provided that:

''(a) STATE PLANNING GRANTS.—

''(1) IN GENERAL.—Not later than 12 months after the date of enactment of this Act [Mar. 9, 2024], the Secretary shall award grants to States for the pur-

pose of developing operational capabilities to promote continuity of care for individuals who are inmates of a public institution and are eligible for medical assistance under the State Medicaid program or are eligible for child health assistance or pregnancy-related assistance under the State CHIP.

''(2) USE OF FUNDS.—A State may use funds awarded under a grant under this subsection for activities and expenses related to complying with the requirement described in section 1902(a)(84)(A) of the Social Security Act (42 U.S.C. 1396a(a)(84)(A)) that a State shall not terminate eligibility for medical assistance, complying with the requirements of sections 1902(a)(84)(D) and 2102(d) of the Social Security Act (42 U.S.C. 1396a(a)(84)(D), 1397bb(d)), or adopting the State plan options described in the subdivision (A) following the last numbered paragraph of section 1905(a) and 2110(b)(7) of the Social Security Act (42 U.S.C. 1396d(a), 1397jj(b)(7)), or other activities and expenses to promote continuity of care for individuals described in paragraph (1). Such activities and expenses may include—

''(A) identifying and addressing operational gaps with respect to complying with such requirements or adopting such options, in collaboration with public institutions, State human services agencies, Medicaid managed care plans, providers, community-based organizations, and other stakeholders;

''(B) establishing standardized processes and automated systems for activities that may include, but are not limited to—

''(i) determining whether an individual is enrolled in a State Medicaid program or State CHIP at the time such individual becomes an inmate of a public institution;

''(ii) allowing an individual who is an inmate of a public institution to submit an application to enroll or renew coverage in a State Medicaid program or State CHIP prior to the individual's release from such public institution;

''(iii) facilitating the delivery of medical assistance under the State Medicaid program or child health assistance or pregnancy-related assistance under the State CHIP to an individual who is eligible for such assistance while the individual is an inmate of a public institution, such as by establishing claims processing and prior authorization request protocols; and

''(iv) in the case of an eligible individual whose coverage under a State Medicaid program or State CHIP was suspended while the individual was an inmate of a public institution, restoring such coverage upon such individual's release from the public institution;

''(C) investing in information technology to—

''(i) enable bi-directional information sharing between public institutions, the State Medicaid and CHIP agencies, and other entities such as managed care plans and providers (in a manner consistent with applicable State and Federal privacy laws), to support care transitions and coordination of treatment (including access to care in the community after release from a public institution); and

''(ii) develop indicators to ensure Federal financial participation for medical assistance furnished under a State Medicaid program or child health assistance or pregnancy-related assistance furnished under a State CHIP is available only for medical assistance or child health assistance or pregnancy-related assistance for items and services for which such participation is permitted while an individual is an inmate of a public institution; and

''(D) establishing oversight and monitoring processes to ensure public institutions and entities with which they contract are compliant with any applicable Medicaid and CHIP requirements.

''(3) LIMITATIONS ON USE OF FUNDS.—A State shall not use funds from a grant awarded under this subsection to—

''(A) provide medical assistance under a State Medicaid program or child health assistance or pregnancy-related assistance under a State CHIP to an individual, or otherwise directly administer health care services for an individual; or

''(B) build prisons, jails, or other carceral facilities, or pay for prison, jail, or other carceral facility-related improvements other than those improvements that are for the direct and primary purpose of meeting the health care needs of individuals who are incarcerated and who are eligible for medical assistance under the State Medicaid program or child health assistance or pregnancy-related assistance under the State CHIP.

''(4) ALLOCATION OF GRANT FUNDS.—In determining the amount of a grant to award to a State that applies for a grant under this subsection, the Secretary shall consider the following factors, relative to other States applying for grants under this subsection:

''(A) The number of individuals in the State who were inmates of non-Federal public institutions (such as State prisons, local and county jails, tribal jails, and youth correctional or detention facilities) and were eligible for medical assistance under a State Medicaid program at any time in calendar year 2022.

''(B) The number of non-Federal public institutions in the State (such as State prisons, local and county jails, tribal jails, and youth correctional or detention facilities).

''(C) The State's progress in developing, implementing, and operating initiatives to promote continuity of care for individuals who are inmates of a public institution and are eligible for medical assistance under the State Medicaid program or are eligible for child health assistance or pregnancy-related assistance under the State CHIP (with favorable consideration given to States with less progress in promoting continuity of care for such individuals).

''(5) APPROPRIATION.—There is appropriated to the Secretary for fiscal year 2024, out of any funds in the Treasury not otherwise appropriated, $113,500,000, to remain available until expended, for the purposes of awarding and administering grants to States under this subsection.

''(b) GUIDANCE TO SUPPORT STATE IMPLEMENTATION AND OPERATIONS.—

''(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act [Mar. 9, 2024], the Secretary shall issue detailed guidance to States that addresses common implementation and operational challenges States face in ensuring access to authorized high-quality, timely, accessible care before, during, and after incarceration for individuals who are eligible for medical assistance under a State Medicaid program or child health assistance or pregnancy-related assistance under a State CHIP.

''(2) CONTENT.—

''(A) COMPLIANCE WITH REQUIREMENTS.—The guidance required under paragraph (1) shall address challenges States face, or are likely to face, in complying with the requirement described in section 1902(a)(84)(A) of the Social Security Act (42 U.S.C. 1396a(a)(84)(A)) that a State shall not terminate eligibility for medical assistance, complying with the requirements of sections 1902(a)(84)(D) and 2102(d) of the Social Security Act (42 U.S.C. 1396a(a)(84)(D), 1397bb(d)), adopting the State plan options described in the subdivision (A) following the last numbered paragraph of section 1905(a) and section 2110(b)(7) of the Social Security Act (42 U.S.C. 1396d(a), 1397jj(b)(7)), and carrying out other activities that are approved by the Secretary to promote continuity of care for individuals who are inmates of a public institution and are eligible for medical assistance under the State Medicaid program or are eligible for child health assistance or pregnancy-related assistance under the State CHIP.

''(B) BEST PRACTICES AND STRATEGIES.—The guidance required under paragraph (1) shall include best

practices and strategies States can use to address implementation and operational challenges related to the requirements described in subparagraph (A), including those related to the following:

''(i) Implementing modifications to improve eligibility and enrollment processes, including, but not limited to, completing applications for assistance under the State Medicaid program or the State CHIP on behalf of inmates, transmitting such applications to State Medicaid and CHIP agencies, and screening individuals who are inmates of public institutions for eligibility for medical assistance that is authorized to be furnished to the individual while the individual is such an inmate.

''(ii) Clarifying the availability of relevant Federal financial participation, including the administrative match under sections 1903 and 2105 of the Social Security Act (42 U.S.C. 1396b, 1397ee), for activities that directly support efforts to identify and enroll eligible individuals in State Medicaid programs and State CHIPs and that directly support the provision of authorized medical assistance, child health assistance, or pregnancy-related assistance, including, but not limited to, data sharing and exchange, and other necessary functions.

''(iii) Expeditiously conducting screening for eligibility under State Medicaid programs and State CHIPs for individuals who are inmates of a public institution, providing application and renewal assistance for those who are not yet enrolled in such programs or whose eligibility needs to be renewed, and coordinating reinstatement of coverage under such programs with managed care enrollment.

''(iv) Ensuring that an individual who is an inmate of a public institution and is eligible for medical assistance under a State Medicaid program or for child health assistance or pregnancy-related assistance under a State CHIP receives, in a timely fashion, any such assistance for which Federal financial participation is authorized, such as, a supply of medications or prescription refill upon release and the services required under sections 1902(a)(84)(D) and 2102(d) of the Social Security Act (42 U.S.C. 1396a(a)(84)(D), 1397bb(d)).

''(v) Establishing community-based provider networks, including those comprised of case managers, for purposes of providing continuity of care to individuals who are eligible for medical assistance under a State Medicaid program or child health assistance or pregnancy-related assistance under a State CHIP before, during, and after incarceration.

''(c) DEFINITIONS.—In this section:

''(1) PUBLIC INSTITUTION.—The term 'public institution' has the meaning given that term in section 1902(nn)(3) of the Social Security Act (42 U.S.C. 1396a(nn)(3)).

''(2) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(3) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act [42 U.S.C. 1396 et seq., 1397aa et seq.].

''(4) STATE CHIP.—The term 'State CHIP' means a State child health plan for child health assistance under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), and includes any waiver of such a plan.

''(5) STATE MEDICAID PROGRAM.—The term 'State Medicaid program' means a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and includes any waiver of such a plan.''

GUIDANCE RELATING TO IMPROVING THE BEHAVIORAL HEALTH WORKFORCE AND INTEGRATION OF CARE UNDER MEDICAID AND CHIP

Pub. L. 118–42, div. G, title I, § 207, Mar. 9, 2024, 138 Stat. 410, provided that:

''(a) GUIDANCE.—Not later than 24 months after the date of enactment of this Act [Mar. 9, 2024], the Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall issue guidance to States regarding the following:

''(1) Opportunities to increase access to the mental health and substance use disorder care providers that participate in Medicaid or CHIP, which may include education, training, recruitment and retention of such providers, with a focus on improving the capacity of this workforce in rural and underserved areas by increasing the number, type, and capacity of providers. The guidance relating to such opportunities shall include the following:

''(A) Best practices from States that have used authorities under titles XI, XIX, or XXI of the Social Security Act (42 U.S.C. 1301 et seq., 1396 et seq., 1397aa et seq.), including initiatives States have implemented under waivers under section 1115 of such Act (42 U.S.C. 1315), for such purposes.

''(B) Opportunities States can leverage to finance, support, and expand the availability of providers of community-based mental health and substance use disorder services who participate in Medicaid and CHIP across the continuum of care, including through the participation of paraprofessionals with behavioral health expertise, such as clinicians with baccalaureate degrees and peer support specialists and including best practices especially pertinent to pediatric care. The guidance shall include examples of innovative policies states [probably should be ''States''] have adopted to expand access to behavioral health services; for example, by establishing more expansive and diverse behavioral health workforce roles such as certified wellness coaches.

''(C) Best practices related to financing, supporting, and expanding the education and training of providers of mental health and substance use disorder services in order to increase the workforce of such providers who participate in Medicaid and CHIP across the continuum of care, including innovative public-private partnerships and including such practices that are especially pertinent to pediatric care.

''(2) Opportunities to promote the integration of mental health or substance use disorder services with primary care services. The guidance relating to such opportunities shall include the following:

''(A) An overview of State options for adopting and expanding value-based payment arrangements and alternative payment models, including accountable care organization-like models and other shared savings programs.

''(B) A description of opportunities for States to use and align existing authorities and resources to finance the integration of mental health or substance use disorder services with primary care services, including with respect to the use of electronic health records in mental health care settings and in substance use disorder care settings.

''(C) Strategies to support integration of mental health or substance use disorder services with primary care services through the use of non-clinical professionals and paraprofessionals, including peer support specialists.

''(D) Examples of specific strategies and models designed to support integration of mental health or substance use disorder services with primary care services for differing age groups, including children and youth and individuals over the age of 65, which may include the collaborative care model or primary care behavioral health model for behavioral health integration.

''(b) INTEGRATION OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES WITH PRIMARY CARE SERVICES.—For purposes of subsection (a)(2), the term 'integration of mental health or substance use disorder services with primary care services' means any of the following:

''(1) The delivery of mental health or substance use disorder services in a setting that is physically located in the same practice or building as a primary care setting, or when at least 1 provider of mental health or substance use disorder services is available in a primary care setting via telehealth.

''(2) The use of behavioral health integration models primarily intended for pediatric populations with non-severe mental health needs that are focused on prevention and early detection and intervention methods through a multidisciplinary collaborative behavioral health team approach co-managed with primary care, to include same-day access to family-focused mental health treatment services.

''(3) Having providers of mental health or substance use disorder services physically co-located in a primary care setting with same-day visit availability.

''(4) Implementing or maintaining enhanced care coordination or targeted case management which includes regular interactions between and within care teams.

''(5) Providing mental health or substance use disorder screening and follow-up assessments, interventions, or services within the same practice or facility as a primary care or physical service setting.

''(6) The use of assertive community treatment that is integrated with or facilitated by a primary care practice.

''(7) Delivery of integrated primary care and mental health care or substance use disorder care in the home or in community-based settings for individuals who are recipients of Medicaid home and community-based services.''

MEDICAID AND TELEHEALTH

Pub. L. 117–159, div. A, title I, §11002, June 25, 2022, 136 Stat. 1316, provided that:

''(a) GUIDANCE TO STATES ON FURNISHING SERVICES THROUGH TELEHEALTH UNDER MEDICAID AND CHIP.—Not later than 18 months after the date of enactment of this Act [June 25, 2022], the Secretary shall provide technical assistance and issue guidance to States on improving access to telehealth for services covered under Medicaid and CHIP, including with respect to:

''(1) How States can adopt flexibilities under Medicaid and CHIP to expand access to covered services via telehealth, including when States may adopt such flexibilities without the need for approval of a State plan amendment or waiver.

''(2) Best practices regarding billing for services, including recommended voluntary billing codes, modifiers, and place of service designations and how such billing codes, modifiers, and designations can be used to create consistent data sets.

''(3) Strategies for integrating telehealth services into value-based care models.

''(4) Best practices from States that have used Medicaid waivers and other Medicaid authorities to expand access to telehealth, including during the COVID–19 public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act [42 U.S.C. 247d] on January 31, 2020, entitled 'Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus', including any renewal of such declaration.

''(5) Strategies to promote the delivery of accessible and culturally competent care via telehealth, including addressing the needs of individuals with disabilities, medically underserved urban and rural communities, racial and ethnic minorities such as American Indians and Alaska Natives, individuals with limited English proficiency, and individuals of different age groups including children, young adults, and seniors;[.]

''(6) Strategies for training and providing resources to providers and patients on the use of telehealth, including working with interpreters to furnish health services and providing resources in multiple languages.

''(7) Integrating the use of existing video platforms that enable multi-person video calls.

''(8) Best practices to support the delivery of covered services under Medicaid and CHIP via telehealth in schools, including specifically for the provision of mental health and substance use disorder services in such settings.

''(9) Strategies for evaluating how the delivery of health services via telehealth affects quality, outcomes, and cost under Medicaid and CHIP.

''(10) Best practices for conveying information to beneficiaries regarding the availability of telehealth as an option to receive services covered under Medicaid and CHIP, including the availability of audio-only telehealth, the ability to receive such services from a patient's home, and requirements related to in-person visits.

''(b) DEFINITIONS.—In this section:

''(1) CHIP.—The term 'CHIP' means the State children's health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

''(2) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(3) SECRETARY.—Except as otherwise provided, the term 'Secretary' means the Secretary of Health and Human Services.

''(4) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act.''

SUPPORTING ACCESS TO HEALTH CARE SERVICES IN SCHOOLS

Pub. L. 117–159, div. A, title I, §11003, June 25, 2022, 136 Stat. 1317, provided that:

''(a) GUIDANCE AND TECHNICAL ASSISTANCE.—

''(1) GUIDANCE.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of this Act [June 25, 2022], the Secretary, in consultation with the Secretary of Education, shall issue guidance to State Medicaid agencies, local educational agencies, and school-based entities to support the delivery of medical assistance to Medicaid and CHIP beneficiaries in school-based settings.

''(B) REQUIRED INFORMATION.—The guidance issued pursuant to subparagraph (A) shall—

''(i) include updates to the May 2003 Medicaid School-Based Administrative Claiming Guide, the 1997 Medicaid and Schools Technical Assistance Guide [probably means the 1997 ''Medicaid and School Health: A Technical Assistance Guide''], and other relevant guidance in effect on the date of enactment of this Act;

''(ii) clarify that payments may be made to school-based entities under Medicaid for delivering assistance under Medicaid, including any such assistance provided in accordance with an individualized education program or under the policy described in the State Medicaid Director letter on payment for services issued on December 15, 2014 (#14-006);

''(iii) outline strategies and tools to reduce administrative burdens on, and simplify billing for, local educational agencies, in particular small and rural local educational agencies, and support compliance with Federal requirements regarding billing, payment, and recordkeeping, including by aligning direct service billing and school-based administrative claiming payment systems;

''(iv) include a comprehensive list of best practices and examples of approved methods that State Medicaid agencies and local educational

agencies have used to pay for, and increase the availability of, assistance under Medicaid, including expanding State programs to include all Medicaid-enrolled students, providing early and periodic screening, diagnostic, and treatment (EPSDT) services in schools, utilizing telehealth, coordinating with community-based mental health and substance use disorder treatment providers and organizations, coordinating with managed care entities, and supporting the provision of culturally competent and trauma-informed care in school settings; and

''(v) provide examples of the types of providers (which may include qualified school health personnel) that States may choose to enroll, deem, or otherwise treat as participating providers for purposes of school-based programs under Medicaid and best practices related to helping such providers enroll in Medicaid for purposes of participating in school-based programs under Medicaid.

''(2) TECHNICAL ASSISTANCE CENTER.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary, in consultation with the Secretary of Education, shall establish a technical assistance center to—

''(i) assist and expand the capacity of State Medicaid agencies and local educational agencies and school-based entities to provide assistance under Medicaid;

''(ii) reduce administrative burdens for such agencies and health centers or entities;

''(iii) support State educational agencies, local educational agencies, and school-based entities in obtaining payment for the provision of assistance under Medicaid;

''(iv) ensure ongoing coordination and collaboration between the Department of Health and Human Services and the Department of Education with respect to the provision of, and payment for, assistance under Medicaid by local educational agencies; and

''(v) provide information to State and local educational agencies and States on how to utilize funding from the Department of Health and Human Services, the Department of Education, and other Federal agencies to ensure payment under Medicaid for assistance provided in school-based settings.

''(B) SMALL AND RURAL SCHOOLS.—The Secretary shall ensure that the technical assistance center includes resources which are specifically designed to help support small and rural local educational agencies in obtaining payment for the provision of assistance under Medicaid.

''(C) REPORTING.—The technical assistance center shall, on a biennial basis, submit to the Secretary a report on the work of the center that identifies the areas where the most assistance was requested.

''(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this subsection, $8,000,000, for fiscal year 2022, to remain available until expended.

''(b) GRANTS.—There is authorized to be appropriated $50,000,000 for fiscal year 2022 for the Secretary to award grants to States for the purpose of implementing, enhancing, or expanding the provision of assistance through school-based entities under Medicaid or CHIP. A State shall not use any grant funds to provide medical assistance, child health assistance, or other health services.

''(c) DEFINITIONS.—For purposes of this section:

''(1) CHIP.—The term 'CHIP' means the State children's health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

''(2) INDIVIDUALIZED EDUCATION PROGRAM.—The term 'individualized education program' has the meaning given such term in section 602(14) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(14)).

''(3) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(4) SCHOOL-BASED ENTITY.—The term 'school-based entity' means—

''(A) a school-based health center, as that term is defined in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)); and

''(B) an entity that provides medical assistance in a school-based setting for which Federal financial participation is allowed under Medicaid.

''(5) SECRETARY.—Except as otherwise provided, the term 'Secretary' means the Secretary of Health and Human Services.

''(6) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act.

''(7) STATE EDUCATIONAL AGENCY; LOCAL EDUCATIONAL AGENCY.—The terms 'State educational agency' and 'local educational agency' have the meaning given those terms in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).''

GUIDANCE REVIEW

Pub. L. 116–260, div. CC, title II, § 209(b)(3), Dec. 27, 2020, 134 Stat. 2988, provided that: ''Not later than 24 months after the date of the enactment of this Act [Dec. 27, 2020], the Secretary of Health and Human Services, through the Centers for Medicare & Medicaid Services, shall assess guidance issued to States by the Centers for Medicare & Medicaid Services relating to Federal requirements for nonemergency transportation to medically necessary services under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and update such guidance as necessary to ensure States have appropriate and current guidance in designing and administering coverage under the Medicaid program of nonemergency transportation to medically necessary services.''

CONSULTATION RELATING TO NONEMERGENCY MEDICAL TRANSPORTATION

Pub. L. 116–260, div. CC, title II, § 209(c), Dec. 27, 2020, 134 Stat. 2989, provided that: ''In the case of a State that exercises the option described in section 1902(a)(70) of the Social Security Act (42 U.S.C. 1396a(a)(7) [1396a(a)(70)]), in establishing a non-emergency medical transportation brokerage program under such section, a State Medicaid agency may consult relevant stakeholders, including stakeholders representing patients, medical providers, Medicaid managed care organizations, brokers for non-emergency medical transportation, and transportation providers (including public transportation providers).''

REEVALUATION OF WAIVERS OF MEDICAID FRAUD CONTROL UNIT REQUIREMENT

Pub. L. 116–94, div. N, title I, § 202(e)(3), Dec. 20, 2019, 133 Stat. 3109, provided that:

''(A) IN GENERAL.—Not later than the date that is 1 year after the date of enactment of this Act [Dec. 20, 2019], the Secretary of Health and Human Services shall reevaluate any waiver approved (and in effect as of the date of enactment of this Act) for Guam, the Northern Mariana Islands, or American Samoa under subsection (a)(61) or subsection (j) of section 1902 of the Social Security Act (42 U.S.C. 1396a) with respect to the requirement to establish a State medicaid fraud control unit (as described in section 1903(q) of such Act (42 U.S.C. 1396b(q))).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring the Secretary of Health and Human Services to terminate or refuse to extend a waiver described in subparagraph (A).''

GUIDANCE ON ACCESS TO MEDICAID FOR FORMER FOSTER YOUTH

Pub. L. 115–271, title I, § 1002(b), Oct. 24, 2018, 132 Stat. 3902, provided that: ''Not later than 1 year after the

date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services shall issue guidance to States, with respect to the State Medicaid programs of such States—

''(1) on best practices for—

''(A) removing barriers and ensuring streamlined, timely access to Medicaid coverage for former foster youth up to age 26; and

''(B) conducting outreach and raising awareness among such youth regarding Medicaid coverage options for such youth; and

''(2) which shall include examples of States that have successfully extended Medicaid coverage to former foster youth up to age 26.''

GUIDANCE TO IMPROVE CARE FOR INFANTS WITH NEONATAL ABSTINENCE SYNDROME AND THEIR MOTHERS

Pub. L. 115–271, title I, §1005(a), Oct. 24, 2018, 132 Stat. 3912, provided that: ''Not later than 1 year after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services shall issue guidance to improve care for infants with neonatal abstinence syndrome and their families. Such guidance shall include—

''(1) best practices from States with respect to innovative or evidenced-based payment models that focus on prevention, screening, treatment, plans of safe care, and postdischarge services for mothers and fathers with substance use disorders and babies with neonatal abstinence syndrome that improve care and clinical outcomes;

''(2) recommendations for States on available financing options under the Medicaid program under title XIX of such Act [probably means title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.] and under the Children's Health Insurance Program under title XXI of such Act [probably means title XXI of the Social Security Act, 42 U.S.C. 1397aa et seq.] for Children's Health Insurance Program Health Services Initiative funds for parents with substance use disorders, infants with neonatal abstinence syndrome, and home-visiting services;

''(3) guidance and technical assistance to State Medicaid agencies regarding additional flexibilities and incentives related to screening, prevention, and postdischarge services, including parenting supports, and infant-caregiver bonding, including breastfeeding when it is appropriate; and

''(4) guidance regarding suggested terminology and ICD codes to identify infants with neonatal abstinence syndrome and neonatal opioid withdrawal syndrome, which could include opioid-exposure, opioid withdrawal not requiring pharmacotherapy, and opioid withdrawal requiring pharmacotherapy.''

MEDICAID SUBSTANCE USE DISORDER TREATMENT VIA TELEHEALTH

Pub. L. 115–271, title I, §1009(a), (b), Oct. 24, 2018, 132 Stat. 3917, provided that:

''(a) DEFINITIONS.—In this section:

''(1) COMPTROLLER GENERAL.—The term 'Comptroller General' means the Comptroller General of the United States.

''(2) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' has the meaning given that term in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

''(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(4) UNDERSERVED AREA.—The term 'underserved area' means a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) and a medically underserved area (according to a designation under section 330(b)(3)(A) of the Public Health Service Act (42 U.S.C. 254b(b)(3)(A))).

''(b) GUIDANCE TO STATES REGARDING FEDERAL REIMBURSEMENT FOR FURNISHING SERVICES AND TREATMENT FOR SUBSTANCE USE DISORDERS UNDER MEDICAID USING SERVICES DELIVERED VIA TELEHEALTH, INCLUDING IN SCHOOL-BASED HEALTH CENTERS.—Not later than 1 year after the date of enactment of this Act [Oct. 24, 2018], the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance to States on the following:

''(1) State options for Federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders, including assessment, medication-assisted treatment, counseling, medication management, and medication adherence with prescribed medication regimes, using services delivered via telehealth. Such guidance shall also include guidance on furnishing services and treatments that address the needs of high-risk individuals, including at least the following groups:

''(A) American Indians and Alaska Natives.

''(B) Adults under the age of 40.

''(C) Individuals with a history of non-fatal overdose.

''(D) Individuals with a co-occurring serious mental illness and substance use disorder.

''(2) State options for Federal reimbursement of expenditures under Medicaid for education directed to providers serving Medicaid beneficiaries with substance use disorders using the hub and spoke model, through contracts with managed care entities, through administrative claiming for disease management activities, and under Delivery System Reform Incentive Payment ('DSRIP') programs.

''(3) State options for Federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders for individuals enrolled in Medicaid in a school-based health center using services delivered via telehealth.''

ENHANCING PATIENT ACCESS TO NON-OPIOID TREATMENT OPTIONS

Pub. L. 115–271, title I, §1010, Oct. 24, 2018, 132 Stat. 3918, provided that: ''Not later than January 1, 2019, the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue 1 or more final guidance documents, or update existing guidance documents, to States regarding mandatory and optional items and services that may be provided under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or under a waiver of such a plan, for non-opioid treatment and management of pain, including, but not limited to, evidence-based, non-opioid pharmacological therapies and non-pharmacological therapies.''

TECHNICAL ASSISTANCE AND SUPPORT FOR INNOVATIVE STATE STRATEGIES TO PROVIDE HOUSING-RELATED SUPPORTS UNDER MEDICAID

Pub. L. 115–271, title I, §1018, Oct. 24, 2018, 132 Stat. 3924, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall provide technical assistance and support to States regarding the development and expansion of innovative State strategies (including through State Medicaid demonstration projects) to provide housing-related supports and services and care coordination services under Medicaid to individuals with substance use disorders.

''(b) REPORT.—Not later than 180 days after the date of enactment of this Act [Oct. 24, 2018], the Secretary shall issue a report to Congress detailing a plan of action to carry out the requirements of subsection (a).''

MEDICAID REENTRY

Pub. L. 115–271, title V, subtitle D, Oct. 24, 2018, 132 Stat. 3965, provided that:

''SEC. 5031. SHORT TITLE.

''This subtitle may be cited as the 'Medicaid Reentry Act'.

''SEC. 5032. PROMOTING STATE INNOVATIONS TO EASE TRANSITIONS INTEGRATION TO THE COMMUNITY FOR CERTAIN INDIVIDUALS.

''(a) STAKEHOLDER GROUP DEVELOPMENT OF BEST PRACTICES; STATE MEDICAID PROGRAM INNOVATION.—

''(1) STAKEHOLDER GROUP BEST PRACTICES.—Not later than 6 months after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services shall convene a stakeholder group of representatives of managed care organizations, Medicaid beneficiaries, health care providers, the National Association of Medicaid Directors, and other relevant representatives from local, State, and Federal jail and prison systems to develop best practices (and submit to the Secretary and Congress a report on such best practices) for States—

''(A) to ease the health care-related transition of an individual who is an inmate of a public institution from the public institution to the community, including best practices for ensuring continuity of health insurance coverage or coverage under the State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], as applicable, and relevant social services; and

''(B) to carry out, with respect to such an individual, such health care-related transition not later than 30 days after such individual is released from the public institution.

''(2) STATE MEDICAID PROGRAM INNOVATION.—The Secretary of Health and Human Services shall work with States on innovative strategies to help individuals who are inmates of public institutions and otherwise eligible for medical assistance under the Medicaid program under title XIX of the Social Security Act transition, with respect to enrollment for medical assistance under such program, seamlessly to the community.

''(b) GUIDANCE ON INNOVATIVE SERVICE DELIVERY SYSTEMS DEMONSTRATION PROJECT OPPORTUNITIES.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue a State Medicaid Director letter, based on best practices developed under subsection (a)(1), regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX of such Act, including systems for, with respect to a period (not to exceed 30 days) immediately prior to the day on which such individuals are expected to be released from such institution—

''(1) providing assistance and education for enrollment under a State plan under the Medicaid program under title XIX of such Act for such individuals during such period; and

''(2) providing health care services for such individuals during such period.

''(c) RULE OF CONSTRUCTION.—Nothing under title XIX of the Social Security Act or any other provision of law precludes a State from reclassifying or suspending (rather than terminating) eligibility of an individual for medical assistance under title XIX of the Social Security Act while such individual is an inmate of a public institution.''

DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION

Pub. L. 114–255, div. A, title V, § 5005(a)(5), Dec. 13, 2016, 130 Stat. 1193, provided that: ''Not later than July 1, 2017, the Secretary of Health and Human Services shall, in consultation with the heads of State agencies administering State Medicaid plans (or waivers of such plans), issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (A)(v) of paragraph (8) of section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)), as added by paragraph (1), for the termination (as described in such paragraph (8)) of the participation of certain providers in the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.] or the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.].''

EXCEPTION FOR STATE LEGISLATION

Pub. L. 114–255, div. A, title V, § 5006(d), Dec. 13, 2016, 130 Stat. 1196, provided that: ''In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this section [amending this section], the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an 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. 13, 2016]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.''

RULE OF CONSTRUCTION RELATED TO MEDICAID COVERAGE OF MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES FURNISHED ON THE SAME DAY

Pub. L. 114–255, div. B, title XII, § 12001, Dec. 13, 2016, 130 Stat. 1272, provided that: ''Nothing in title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall be construed as prohibiting separate payment under the State plan under such title (or under a waiver of the plan) for the provision of a mental health service or primary care service under such plan, with respect to an individual, because such service is—

''(1) a primary care service furnished to the individual by a provider at a facility on the same day a mental health service is furnished to such individual by such provider (or another provider) at the facility; or

''(2) a mental health service furnished to the individual by a provider at a facility on the same day a primary care service is furnished to such individual by such provider (or another provider) at the facility.''

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Pub. L. 113–93, title II, § 223, Apr. 1, 2014, 128 Stat. 1077, as amended by Pub. L. 116–16, § 4, Apr. 18, 2019, 133 Stat. 859; Pub. L. 116–29, § 1, July 5, 2019, 133 Stat. 1031; Pub. L. 116–39, § 2, Aug. 6, 2019, 133 Stat. 1061; Pub. L. 116–59, div. B, title III, § 1301, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title III, § 1301, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, § 201, Dec. 20, 2019, 133 Stat. 3103; Pub. L. 116–136, div. A, title III, § 3814(a), (b), Mar. 27, 2020, 134 Stat. 430, 431; Pub. L. 116–159, div. C, title III, § 2304, Oct. 1, 2020, 134 Stat. 732; Pub. L. 116–215, div. B, title I, § 1104, Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, § 206, Dec. 27, 2020, 134 Stat. 2984; Pub. L. 117–159, div. A, title I, § 11001, June 25, 2022, 136 Stat. 1314, provided that:

''(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—

''(1) PUBLICATION.—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

''(2) REQUIREMENTS.—The criteria published under this subsection shall include criteria with respect to the following:

''(A) STAFFING.—Staffing requirements, including criteria that staff have diverse disciplinary back-

grounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

''(B) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.

''(C) CARE COORDINATION.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

''(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

''(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

''(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

''(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 [probably should be 1701] of title 38, United States Code.

''(v) Inpatient acute care hospitals and hospital outpatient clinics.

''(D) SCOPE OF SERVICES.—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

''(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

''(ii) Screening, assessment, and diagnosis, including risk assessment.

''(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

''(iv) Outpatient mental health and substance use services.

''(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

''(vi) Targeted case management.

''(vii) Psychiatric rehabilitation services.

''(viii) Peer support and counselor services and family supports.

''(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

''(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

''(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 [450f] et seq.) [now 25 U.S.C. 5321 et seq.], or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 [1651] et seq.).

''(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

''(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d).

''(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

''(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

''(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act [Apr. 1, 2014].

''(c) PLANNING GRANTS.—

''(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d).

''(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

''(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

''(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

''(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

''(3) ADDITIONAL PLANNING GRANTS FOR STATES.—In addition to the planning grants awarded under paragraph (1), as soon as practicable after the date of enactment of this paragraph [June 25, 2022], the Secretary shall award planning grants to States (other than States selected to conduct demonstration programs under paragraph (1) or (8) of subsection (d)) to develop proposals to participate in time-limited demonstration programs described in subsection (d) so that, beginning July 1, 2024, and every 2 years thereafter, up to 10 additional States may participate in the demonstration programs described in subsection (d) in accordance with paragraph (9) of that subsection.

''(d) DEMONSTRATION PROGRAMS.—

''(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

''(2) APPLICATION REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

''(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

''(i) The target Medicaid population to be served under the demonstration program.

''(ii) A list of participating certified community behavioral health clinics.

''(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

''(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

''(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

''(vi) Such other information as the Secretary may require relating to the demonstration program including with respect to determining the soundness of the proposed prospective payment system.

''(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Subject to paragraphs (8) and (9), not more than 8 States shall be selected to conduct demonstration programs that meet the requirements of this subsection through September 30, 2025.

''(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

''(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

''(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

''(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

''(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

''(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

''(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

''(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

''(B) FEDERAL MATCHING PERCENTAGE.—Subject to subparagraph (C)(iii), the Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished by a State participating in an ongoing demonstration program under this subsection—

''(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

''(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

''(C) LIMITATIONS.—

''(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

''(I) that are described in the demonstration program application in accordance with paragraph (2)(iv);

''(II) for which payment is available under the State Medicaid program; and

''(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

''(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

''(I) for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; or

''(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act [Apr. 1, 2014].

''(iii) PAYMENTS FOR AMOUNTS EXPENDED AFTER 2019.—The Federal matching percentage applicable under subparagraph (B) to amounts expended by a State participating in the demonstration program under this subsection shall—

''(I) in the case of a State participating in the demonstration program as of January 1, 2020, apply to amounts expended by the State through September 30, 2025;

''(II) in the case of a State selected to participate in the demonstration program under paragraph (8), during the first 24 fiscal quarter period (or any portion of such period) that the State participates in the demonstration program; and

''(III) in the case of a State selected to participate in the demonstration program under paragraph (9), during the first 16 fiscal quarter period (or any portion of such period) that the State participates in the demonstration program.

''(D) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that participated in a demonstration program under this subsection that has ended from receiving Federal financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for amounts expended by the State under a State plan under such title (or a waiver of such plan) for providing medical assistance for items and services, and carrying out activities, including continuing to pay for services under the prospective payment system established under subsection (c), that were provided or carried out by the State under the demonstration program, to the extent such financial participation is otherwise available under such title.

''(6) WAIVER OF STATEWIDENESS REQUIREMENT.—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be necessary to conduct demonstration programs in accordance with the requirements of this subsection.

''(7) ANNUAL REPORTS.—

''(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter through the year in which the last demonstration under this section ends, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

''(i) an assessment of access to community-based mental health services under the Medicaid

program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

''(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

''(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

''(B) RECOMMENDATIONS.—Not later than September 30, 2025, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated. Such recommendations shall include data collected after 2019, where feasible.

''(C) FINAL EVALUATION.—Not later than 24 months after all demonstration programs under this section have ended, the Secretary shall submit to Congress a final evaluation of such programs.

''(8) ADDITIONAL PROGRAMS.—

''(A) IN GENERAL.—Not later than 6 months after the date of enactment of this paragraph [Mar. 27, 2020], in addition to the 8 States selected under paragraph (1), the Secretary shall select 2 States to conduct demonstration programs that meet the requirements of this subsection for 6 years.

''(B) SELECTION OF STATES.—

''(i) IN GENERAL.—Subject to clause (ii), in selecting States under this paragraph, the Secretary—

''(I) shall select States that—

''(aa) were awarded planning grants under subsection (c); and

''(bb) applied to participate in the demonstration programs under this subsection under paragraph (1) but, as of the date of enactment of this paragraph, were not selected to participate under paragraph (1); and

''(II) shall use the results of the Secretary's evaluation of each State's application under paragraph (1) to determine which States to select, and shall not require the submission of any additional application.

''(C) REQUIREMENTS FOR SELECTED STATES.—Prior to services being delivered under the demonstration authority in a State selected under this paragraph, the State shall—

''(i) submit a plan to monitor certified community behavioral health clinics under the demonstration program to ensure compliance with certified community behavioral health criteria during the demonstration period; and

''(ii) commit to collecting data, notifying the Secretary of any planned changes that would deviate from the prospective payment system methodology outlined in the State's demonstration application, and obtaining approval from the Secretary for any such change before implementing the change.

''(9) FURTHER ADDITIONAL PROGRAMS.—

''(A) IN GENERAL.—In addition to the States selected under paragraphs (1) and (8), the Secretary shall select any State that meets the requirements described in subparagraph (B) to conduct a demonstration program that meets the requirements of this subsection for 4 years.

''(B) REQUIREMENTS.—The requirements described in this subparagraph with respect to a State are that the State—

''(i) was awarded a planning grant under paragraph (1) or (3) of subsection (c); and

''(ii) submits an application (in addition to any application that the State may have previously submitted under this section) that includes the information described in paragraph (2)(B).

''(C) REQUIREMENTS FOR SELECTED STATES.—The requirements applicable to States selected under paragraph (8) pursuant to subparagraph (C) of such paragraph shall apply in the same manner to States selected under this paragraph.

''(D) LIMITATION.—The Secretary shall not select more than 10 States to conduct a demonstration program under this paragraph for each 2 fiscal year period.

''(e) DEFINITIONS.—In this section:

''(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms 'Federally-qualified health center services', 'Federally-qualified health center', 'rural health clinic services', and 'rural health clinic' have the meanings given those terms in section 1905(*l*) of the Social Security Act (42 U.S.C. 1396d(*l*)).

''(2) ENHANCED FMAP.—The term 'enhanced FMAP' has the meaning given that term in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b) [1397ee(b)]) but without regard to the second and third sentences of that section.

''(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(f) FUNDING.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

''(A) for purposes of carrying out subsections (a), (b), and (d)(7), $2,000,000 for fiscal year 2014;

''(B) for purposes of awarding planning grants under subsection (c), $25,000,000 for fiscal year 2016; and

''(C) for purposes of awarding planning grants under subsection (c)(3), providing technical assistance to States applying for grants under such subsection, and carrying out demonstration programs under subsection (d), $40,000,000 for fiscal year 2023, to remain available until expended.

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.''

REPORTS TO CONGRESS

Pub. L. 111–148, title II, §2001(d)(2), Mar. 23, 2010, 124 Stat. 278, provided that: ''Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.''

DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION

Pub. L. 111–148, title II, §2704, Mar. 23, 2010, 124 Stat. 323, provided that:

''(a) AUTHORITY TO CONDUCT PROJECT.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

''(A) with respect to an episode of care that includes a hospitalization; and

''(B) for concurrent physicians services provided during a hospitalization.

''(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

''(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

''(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure [sic] that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

''(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

''(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

''(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

''(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

''(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

''(c) WAIVER OF PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act [42 U.S.C. 1396 et seq., 1395 et seq., 1301 et seq.] as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

''(d) EVALUATION AND REPORT.—

''(1) DATA.—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

''(2) REPORT.—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.''

PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT

Pub. L. 111–148, title II, § 2706, Mar. 23, 2010, 124 Stat. 325, provided that:

''(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act [42 U.S.C. 1395jjj] (as added by section 3022).

''(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

''(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) REQUIREMENTS.—

''(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

''(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.] that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

''(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

''(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.''

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Pub. L. 111–148, title II, § 2707, Mar. 23, 2010, 124 Stat. 326, as amended by Pub. L. 114–97, § 2(a)–(d), Dec. 11, 2015, 129 Stat. 2194–2197, provided that:

''(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to an institution for mental diseases that is publicly or not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

''(1) have attained age 21, but have not attained age 65;

''(2) are eligible for medical assistance under such plan; and

''(3) require such medical assistance to stabilize an emergency medical condition.

''(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish [sic] a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

''(c) ELIGIBLE STATE DEFINED.—

''(1) IN GENERAL.—Except as otherwise provided in paragraph (4), an eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

''(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

''(3) SELECTION.—Except as otherwise provided in paragraph (4), a State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

''(4) NATIONWIDE AVAILABILITY.—In the event that the Secretary makes a recommendation pursuant to subsection (f)(4) that the demonstration project be expanded on a national basis, any State that has submitted or submits an application pursuant to paragraph (2) shall be deemed to have been selected to be an eligible State to participate in the demonstration project.

''(d) LENGTH OF DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the demonstration project established under this section shall be conducted for a period of 3 consecutive years.

''(2) TEMPORARY EXTENSION OF PARTICIPATION ELIGIBILITY FOR SELECTED STATES.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (4), a State selected as an eligible State to participate in the demonstration project on or prior to March 13, 2012, shall, upon the request of the State, be permitted to continue to participate in the demonstration project through September 30, 2016, if—

''(i) the Secretary determines that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such extension for that State is projected not to increase net program spending under title XIX of the Social Security Act.

''(B) NOTICE OF PROJECTIONS.—The Secretary shall provide each State selected to participate in the demonstration project on or prior to March 13, 2012, with notice of the determination and certification made under subparagraph (A) for the State.

''(3) EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—

''(A) ADDITIONAL EXTENSION.—Taking into account the recommendations submitted to Congress under subsection (f)(3), the Secretary may permit an eligible State participating in the demonstration project as of the date such recommendations are submitted to continue to participate in the project through December 31, 2019, if, with respect to the State—

''(i) the Secretary determines that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act.

''(B) OPTION FOR EXPANSION TO ADDITIONAL STATES.—Taking into account the recommendations submitted to Congress pursuant to subsection (f)(3), the Secretary may expand the number of eligible States participating in the demonstration project through December 31, 2019, if, with respect to any new eligible State—

''(i) the Secretary determines that the participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act.

''(C) NOTICE OF PROJECTIONS.—The Secretary shall provide each State participating in the demonstration project as of the date the Secretary submits recommendations to Congress under subsection (f)(3), and any additional State that applies to be added to the demonstration project, with notice of the determination and certification made for the State under subparagraphs (A) and (B), respectively, and the standards used to make such determination and certification—

''(i) in the case of a State participating in the demonstration project as of the date the Secretary submits recommendations to Congress under subsection (f)(3), not later than August 31, 2016; and

''(ii) in the case of an additional State that applies to be added to the demonstration project, prior to the State making a final election to participate in the project.

''(4) AUTHORITY TO ENSURE BUDGET NEUTRALITY.—The Secretary annually shall review each participating State's demonstration project expenditures to ensure compliance with the requirements of paragraphs (2)(A)(i), (2)(A)(ii), (3)(A)(i), (3)(A)(ii), (3)(B)(i), and (3)(B)(ii) (as applicable). If the Secretary determines with respect to a State's participation in the demonstration project that the State's net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] has increased as a result of the State's participation in the project, the Secretary shall treat the demonstration project excess expenditures of the State as an overpayment under title XIX of the Social Security Act.

''(e) FUNDING.—

''(1) APPROPRIATION.—

''(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

''(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act [sic] and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

''(2) AVAILABILITY [sic].—Funds appropriated under paragraph (1) shall remain available for obligation until expended.

''(3) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application (other than States deemed to be eligible States through the application of subsection (c)(4)), as determined by the Secretary.

''(4) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State (other than a State deemed to be an eligible State through the application of subsection (c)(4)), from its allocation under paragraph (3), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). In addition to any payments made to an eligible State under the preceding sentence, the Secretary shall, during any period in effect under paragraph (2) or (3) of subsection (d), or during any period in which a law described in subsection (f)(4)(C) is in effect, pay each eligible State (including any State deemed to be an eligible State through the application of subsection (c)(4)), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter during such period for medical assistance described in subsection (a). Payments made to a State for emergency psychiatric demonstration services under this section during the extension period shall be treated as medical assistance under the State plan for purposes of section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

''(f) EVALUATION, REPORT, AND RECOMMENDATIONS TO CONGRESS.—

''(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

''(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

''(B) An assessment of discharge planning by participating hospitals.

''(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

''(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

''(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

''(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

''(3) RECOMMENDATION TO CONGRESS REGARDING EXTENSION AND EXPANSION OF PROJECT.—Not later than September 30, 2016, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

''(A) whether the demonstration project should be continued after September 30, 2016; and

''(B) whether the demonstration project should be expanded to additional States.

''(4) RECOMMENDATION TO CONGRESS REGARDING PERMANENT EXTENSION AND NATIONWIDE EXPANSION.—

''(A) IN GENERAL.—Not later than April 1, 2019, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

''(i) whether the demonstration project should be permanently continued after December 31, 2019, in 1 or more States; and

''(ii) whether the demonstration project should be expanded (including on a nationwide basis).

''(B) REQUIREMENTS.—Any recommendation submitted under subparagraph (A) to permanently continue the project in a State, or to expand the project to 1 or more other States (including on a nationwide basis) shall include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that permanently continuing the project in a particular State, or expanding the project to a particular State (or all States) is projected not to increase net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

''(C) CONGRESSIONAL APPROVAL REQUIRED.—The Secretary shall not permanently continue the demonstration project in any State after December 31, 2019, or expand the demonstration project to any additional State after December 31, 2019, unless Congress enacts a law approving either or both such actions and the law includes provisions that—

''(i) ensure that each State's participation in the project complies with budget neutrality requirements; and

''(ii) require the Secretary to treat any expenditures of a State participating in the demonstration project that are [in] excess of the expenditures projected under the budget neutrality standard for the State as an overpayment under title XIX of the Social Security Act.

''(5) FUNDING.—Of the unobligated balances of amounts available in the Centers for Medicare & Medicaid Services Program Management account, $100,000 shall be available to carry out this subsection and shall remain available until expended.

''(g) WAIVER AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) [now (32)] of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

''(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act [42 U.S.C. 1301 et seq., 1396 et seq.] (including the requirements of sections 1902(a)(1) [42 U.S.C. 1396a(a)(1)] (relating to statewideness) and 1902(1)(10)(B) [probably means 1902(a)(1)(10)(B), 42 U.S.C. 1396a(a)(1)(10)(B)] (relating to comparability)) only to [the] extent necessary to carry out the demonstration project under this section.

''(h) DEFINITIONS.—In this section:

''(1) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

''(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

''(3) INSTITUTION FOR MENTAL DISEASES.—The term 'institution for mental diseases' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

''(4) MEDICAL ASSISTANCE.—The term 'medical assistance' has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

''(5) STABILIZED.—The term 'stabilized' means, with respect to an individual, that the emergency medical

condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

''(6) STATE.—The term 'State' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).''

[Pub. L. 114–97, § 2(e), Dec. 11, 2015, 129 Stat. 2198, provided that: ''The amendments made by this section [amending section 2707 of Pub. L. 111–148, set out above] shall take effect on the date of the enactment of this Act [Dec. 11, 2015].'']

INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID

Pub. L. 111–148, title IV, § 4108, Mar. 23, 2010, 124 Stat. 561, provided that:

''(a) INITIATIVES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary [of Health and Human Services] shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

''(i) successfully participate in a program described in paragraph (3); and

''(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

''(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

''(2) DURATION.—

''(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

''(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

''(3) PROGRAM DESCRIBED.—

''(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

''(i) Ceasing use of tobacco products.

''(ii) Controlling or reducing their weight.

''(iii) Lowering their cholesterol.

''(iv) Lowering their blood pressure.

''(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

''(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

''(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act [42 U.S.C. 1396a(a)(1)] for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

''(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

''(4) APPLICATION.—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

''(b) EDUCATION AND OUTREACH CAMPAIGN.—

''(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

''(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

''(c) IMPACT.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

''(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

''(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

''(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

''(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

''(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

''(d) EVALUATIONS AND REPORTS.—

''(1) INDEPENDENT ASSESSMENT.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

''(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

''(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

''(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

''(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

''(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

''(A) the specific uses of the grant funds;

''(B) an assessment of program implementation and lessons learned from the programs;

''(C) an assessment of quality improvements and clinical outcomes under such programs; and

''(D) estimates of cost savings resulting from such programs.

''(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

''(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

''(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

''(g) DEFINITIONS.—In this section:

''(1) MEDICAID BENEFICIARY.—The term 'Medicaid beneficiary' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

''(2) STATE.—The term 'State' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).''

COORDINATION OF EXPANSION OF THE RECOVERY AUDIT CONTRACTOR PROGRAM; REGULATIONS

Pub. L. 111–148, title VI, § 6411(a)(2), Mar. 23, 2010, 124 Stat. 775, provided that:

''(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

''(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection [amending this section] and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.''

ANNUAL REPORT

Pub. L. 111–148, title VI, § 6411(c), Mar. 23, 2010, 124 Stat. 775, provided that: ''The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include [in] such reports recommendations for expanding or improving the program.''

PURPOSES OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, § 5000(a), Feb. 17, 2009, 123 Stat. 496, provided that: ''The purposes of this title [enacting section 1320b–24 of this title, amending this section and sections 1396*o*, 1396*o*–1, 1396p, 1396r–4, 1396r–6, 1396u–2, 1396u–3, and 1397gg of this title, and enacting provisions set out as notes under this section and sections 1396d and 1396r–6 of this title] are as follows:

''(1) To provide fiscal relief to States in a period of economic downturn.

''(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.''

LIMITATION ON WAIVER AUTHORITY

Pub. L. 111–3, title II, § 211(a)(2), Feb. 4, 2009, 123 Stat. 52, provided that: ''Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary [of Health and Human Services] may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State.''

EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM

Pub. L. 110–90, § 4, Sept. 29, 2007, 121 Stat. 985, which required that an automated, secure, web-based asset verification request and response process be applied to Medicaid's asset eligibility determinations in certain States during a certain period, was repealed by Pub. L. 110–252, title VII, § 7001(d)(4), June 30, 2008, 122 Stat. 2394.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Pub. L. 109–171, title VI, § 6063, Feb. 8, 2006, 120 Stat. 99, provided that:

''(a) IN GENERAL.—The Secretary is authorized to conduct, during each of fiscal years 2007 through 2011, demonstration projects (each in the section referred to as a 'demonstration project') in accordance with this section under which up to 10 States (as defined for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) are awarded grants, on a competitive basis, to test the effectiveness in improving or maintaining a child's functional level and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment for children enrolled in the Medicaid program under title XIX of such Act.

''(b) APPLICATION OF TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to the provisions of this section, for the purposes of the demonstration projects, and only with respect to children enrolled under such demonstration projects, a psychiatric residential treatment facility (as defined in section 483.352 of title 42 of the Code of Federal Regulations) shall be deemed to be a facility specified in section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), and to be included in each reference in such section 1915(c) to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

''(2) STATE OPTION TO ASSURE CONTINUITY OF MEDICAID COVERAGE.—Upon the termination of a demonstration project under this section, the State that conducted the project may elect, only with respect to a child who is enrolled in such project on the termination date, to continue to provide medical assistance for coverage of home and community-based alternatives to psychiatric residential treatment for the child in accordance with section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as modified through the application of paragraph (1). Expenditures incurred for providing such medical assistance shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

''(c) TERMS OF DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—Except as otherwise provided in this section, a demonstration project shall be subject to the same terms and conditions as apply to a waiv-

er under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), including the waiver of certain requirements under the first sentence of paragraph (3) of such section but not applying the second sentence of such paragraph.

''(2) BUDGET NEUTRALITY.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under that title if the demonstration projects under this section had not been implemented.

''(3) EVALUATION.—The application for a demonstration project shall include an assurance to provide for such interim and final evaluations of the demonstration project by independent third parties, and for such interim and final reports to the Secretary, as the Secretary may require.

''(d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE AND FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), a demonstration project approved by the Secretary under this section shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

''(2) LIMITATION.—In no case may the amount of payments made by the Secretary under this section for State demonstration projects for a fiscal year exceed the amount available under subsection (f)(2)(A) for such fiscal year.

''(e) SECRETARY'S EVALUATION AND REPORT.—The Secretary shall conduct an interim and final evaluation of State demonstration projects under this section and shall report to the President and Congress the conclusions of such evaluations within 12 months of completing such evaluations.

''(f) FUNDING.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there are appropriated, from amounts in the Treasury not otherwise appropriated, for fiscal years 2007 through 2011, a total of $218,000,000, of which—

''(A) the amount specified in paragraph (2) shall be available for each of fiscal years 2007 through 2011; and

''(B) a total of $1,000,000 shall be available to the Secretary for the evaluations and report under subsection (e).

''(2) FISCAL YEAR LIMIT.—

''(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph for a fiscal year is the amount specified in subparagraph (B) for the fiscal year plus the difference, if any, between the total amount available under this paragraph for prior fiscal years and the total amount previously expended under paragraph (1)(A) for such prior fiscal years.

''(B) FISCAL YEAR AMOUNTS.—The amount specified in this subparagraph for—

''(i) fiscal year 2007 is $21,000,000;

''(ii) fiscal year 2008 is $37,000,000;

''(iii) fiscal year 2009 is $49,000,000;

''(iv) fiscal year 2010 is $53,000,000; and

''(v) fiscal year 2011 is $57,000,000.''

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

Pub. L. 116–260, div. CC, title II, §204(g), Dec. 27, 2020, 134 Stat. 2983, provided that: ''Not later than 1 year after the date of the enactment of this Act [Dec. 27, 2020], the Secretary shall update the terms and conditions of any approved MFP demonstration project under section 6071 of the Deficit Reduction Act of 2005 [Pub. L. 109–171] (42 U.S.C. 1396a note) in effect on the date of the enactment of this Act to ensure that such terms and conditions are the same as are required for any new State applicant for such project under the amendments made by this section.''

Pub. L. 109–171, title VI, §6071, Feb. 8, 2006, 120 Stat. 102, as amended by Pub. L. 111–148, title II, §2403(a), (b)(1), Mar. 23, 2010, 124 Stat. 304, 305; Pub. L. 116–3, §2, Jan. 24, 2019, 133 Stat. 6; Pub. L. 116–16, §5, Apr. 18, 2019, 133 Stat. 859; Pub. L. 116–39, §4, Aug. 6, 2019, 133 Stat. 1061; Pub. L. 116–94, div. N, title I, §205, Dec. 20, 2019, 133 Stat. 3112; Pub. L. 116–136, div. A, title III, §3811, Mar. 27, 2020, 134 Stat. 429; Pub. L. 116–159, div. C, title III, §2301, Oct. 1, 2020, 134 Stat. 731; Pub. L. 116–215, div. B, title I, §1107, Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §204(a), (b)(1), (c)–(f), Dec. 27, 2020, 134 Stat. 2980–2983; Pub. L. 117–328, div. FF, title V, §5114, Dec. 29, 2022, 136 Stat. 5940, provided that:

''(a) PROGRAM PURPOSE AND AUTHORITY.—The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an 'MFP demonstration project') designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

''(1) REBALANCING.—Increase the use of home and community-based, rather than institutional, long-term care services.

''(2) MONEY FOLLOWS THE PERSON.—Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

''(3) CONTINUITY OF SERVICE.—Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

''(4) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

''(b) DEFINITIONS.—For purposes of this section:

''(1) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.—The term 'home and community-based long-term care services' means, with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to an MFP demonstration project of a State, an individual in the State—

''(A) who, immediately before beginning participation in the MFP demonstration project—

''(i) resides (and has resided for a period of not less than 60 consecutive days) in an inpatient facility;

''(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

''(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], the individual must continue to require at least the level of care which had resulted in admission to the institution; and

''(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

''(3) INPATIENT FACILITY.—The term 'inpatient facility' means a hospital, nursing facility, or inter-

mediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

''(4) MEDICAID.—The term 'Medicaid' means, with respect to a State, the State program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any waiver or demonstration under such title or under section 1115 of such Act [42 U.S.C. 1315] relating to such title).

''(5) QUALIFIED HCB PROGRAM.—The term 'qualified HCB program' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

''(6) QUALIFIED RESIDENCE.—The term 'qualified residence' means, with respect to an eligible individual—

''(A) a home owned or leased by the individual or the individual's family member;

''(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

''(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

''(7) QUALIFIED EXPENDITURES.—The term 'qualified expenditures' means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

''(8) SELF-DIRECTED SERVICES.—The term 'self-directed' means, with respect to home and community-based long-term care services for an eligible individual, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative (as defined by the Secretary), including the amount, duration, scope, provider, and location of such services, under the State Medicaid program consistent with the following requirements:

''(A) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

''(B) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that—

''(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

''(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

''(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

''(iv) is developed through a person-centered process that—

''(I) is directed by the individual or the individual's authorized representative;

''(II) builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities; and

''(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

''(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

''(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

''(C) BUDGET PROCESS.—With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)—

''(i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

''(ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

''(iii) provides a procedure to evaluate expenditures under such budgets.

''(9) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

''(10) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(c) STATE APPLICATION.—A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

''(1) ASSURANCE OF A PUBLIC DEVELOPMENT PROCESS.—The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

''(2) OPERATION IN CONNECTION WITH QUALIFIED HCB PROGRAM TO ASSURE CONTINUITY OF SERVICES.—The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

''(3) DEMONSTRATION PROJECT PERIOD.—The application shall specify the period of the MFP demonstration project.

''(4) SERVICE AREA.—The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or 1 or more geographic areas of the State.

''(5) TARGETED GROUPS AND NUMBERS OF INDIVIDUALS SERVED.—The application shall specify—

''(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

''(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

''(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

''(6) INDIVIDUAL CHOICE, CONTINUITY OF CARE.—The application shall contain assurances that—

''(A) each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project;

''(B) each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive

home and community-based long-term care services;

''(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based long-term care services to each individual who completes participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to requiring a level of care provided in an inpatient facility and continuing to require such services, and, if the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], meeting the requirement for at least the level of care which had resulted in the individual's admission to the institution).

''(7) EXPENDITURES.—The application shall—

''(A) provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services; and

''(B)(i) specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services;

''(ii) describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a); and

''(iii) include a work plan that describes for each Federal fiscal year that occurs during the proposed MFP demonstration project—

''(I) the use of grant funds for each proposed initiative that is designed to accomplish the objective described in subsection (a)(1), including a funding source for each activity that is part of each such proposed initiative;

''(II) an evaluation plan that identifies expected results for each such proposed initiative; and

''(III) a sustainability plan for components of such proposed initiatives that are intended to improve transitions, which shall be updated with actual expenditure information for each Federal fiscal year that occurs during the MFP demonstration project; and

''(iv) contain assurances that grant funds used to accomplish the objective described in subsection (a)(1) shall be obligated not later than 24 months after the date on which the funds are awarded and shall be expended not later than 60 months after the date on which the funds are awarded (unless the Secretary waives either such requirement).

''(8) MONEY FOLLOWS THE PERSON.—The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other barriers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.

''(9) MAINTENANCE OF EFFORT AND COST-EFFECTIVENESS.—The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that—

''(A) total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for—

''(i) fiscal year 2005; or

''(ii) any succeeding fiscal year before the first year of the MFP demonstration project; and

''(B) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

''(10) WAIVER REQUESTS.—The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.

''(11) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—The application shall include—

''(A) a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and

''(B) an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement systems for home and community-based long-term care services.

''(12) OPTIONAL PROGRAM FOR SELF-DIRECTED SERVICES.—If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:

''(A) MEETING REQUIREMENTS.—A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.

''(B) VOLUNTARY ELECTION.—A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.

''(C) STATE SUPPORT IN SERVICE PLAN DEVELOPMENT.—Satisfactory assurances that the State will provide support to eligible individuals who self-direct in developing and implementing their service plans.

''(D) OVERSIGHT OF RECEIPT OF SERVICES.—Satisfactory assurances that the State will provide oversight of eligible individual's receipt of such self-directed services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

''(13) REPORTS AND EVALUATION.—The application shall provide that—

''(A) the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reliable comparisons of MFP demonstration projects across States, and in such manner as will meet the reporting requirements set forth for the Transformed Medicaid Statistical Information System (T–MSIS);

''(B) the State shall report on a quarterly basis on the use of grant funds by distinct activity, as described in the approved work plan, and by specific population as targeted by the State;

''(C) if the State fails to report the information required under subparagraph (B), fails to report such information on a quarterly basis, or fails to make progress under the approved work plan, the State shall implement a corrective action plan approved by the Secretary; and

''(D) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

''(d) SECRETARY'S AWARD OF COMPETITIVE GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

''(2) SELECTION AND MODIFICATION OF STATE APPLICATIONS.—In selecting State applications for the awarding of such a grant, the Secretary—

''(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

''(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

''(C) shall give preference to State applications proposing—

''(i) to provide transition assistance to eligible individuals within multiple target groups; and

''(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services, as defined in subsection (b)(8); and

''(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

''(3) WAIVER AUTHORITY.—The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

''(A) STATEWIDENESS.—Section 1902(a)(1) [42 U.S.C. 1396a(a)(1)], in order to permit implementation of a State initiative in a selected area or areas of the State.

''(B) COMPARABILITY.—Section 1902(a)(10)(B), in order to permit a State initiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

''(C) INCOME AND RESOURCES ELIGIBILITY.—Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

''(D) PROVIDER AGREEMENTS.—Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

''(4) CONDITIONAL APPROVAL OF OUTYEAR GRANT.—In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

''(A) NUMERICAL BENCHMARKS.—The State must demonstrate to the satisfaction of the Secretary that it is meeting numerical benchmarks specified in the grant agreement for—

''(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

''(ii) numbers of eligible individuals assisted to transition to qualified residences.

''(B) QUALITY OF CARE.—The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under subsection (c)(11) to assure the health and welfare of MFP demonstration project participants.

''(C) CORRECTIVE ACTION PLAN PROGRESS.—In the case of a State required to implement a corrective action plan under subparagraph (C) of subsection (c)(13), the State must implement such plan and demonstrate progress in reporting information under subparagraph (B) of such subsection or progress under the approved work plan (as applicable).

''(e) PAYMENTS TO STATES; CARRYOVER OF UNUSED GRANT AMOUNTS.—

''(1) PAYMENTS.—For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of—

''(A) the MFP-enhanced FMAP (as defined in paragraph (5)) of the amount of qualified expenditures made during such quarter; or

''(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

''(2) CARRYOVER OF UNUSED AMOUNTS.—Any portion of a State grant award for a fiscal year under this section remaining at the end of such fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3). Any portion of a State grant award for a fiscal year under this section that is unexpended by the State at the end of the fourth succeeding fiscal year shall be rescinded by the Secretary and added to the appropriation for the fifth succeeding fiscal year.

''(3) REAWARDING OF CERTAIN UNUSED AMOUNTS.—In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

''(4) PREVENTING DUPLICATION OF PAYMENT.—The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)]. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

''(5) MFP-ENHANCED FMAP.—For purposes of paragraph (1)(A), the 'MFP-enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b) [42 U.S.C. 1396d(b)]) for the State increased by a number of percentage points equal to 50 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent; but in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

''(f) QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT.—

''(1) IN GENERAL.—The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including—

''(A) dissemination of information on promising practices;

''(B) guidance on system design elements addressing the unique needs of participating beneficiaries;

''(C) ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and

''(D) guidance on remedying programmatic and systemic problems.

''(2) FUNDING.—From the amounts appropriated under subsection (h)(1), $3,000,000 shall be available to

the Secretary to carry out this subsection. Such amount shall remain available until expended.

''(g) RESEARCH AND EVALUATION.—

''(1) IN GENERAL.—The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of projected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.

''(2) FINAL REPORT.—The Secretary shall make a final report to the President and Congress, not later than September 30, 2026, reflecting the evaluation described in paragraph (1) and providing findings and conclusions on the conduct and effectiveness of MFP demonstration projects.

''(3) FUNDING.—From the amounts appropriated under subsection (h)(1) for each of fiscal years 2008 through 2016, and for each of fiscal years 2021 through 2023[,] not more than $1,100,000 per year shall be available to the Secretary to carry out this subsection.

''(h) APPROPRIATIONS.—

''(1) IN GENERAL.—There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section—

''(A) $250,000,000 for the portion of fiscal year 2007 beginning on January 1, 2007, and ending on September 30, 2007;

''(B) $300,000,000 for fiscal year 2008;

''(C) $350,000,000 for fiscal year 2009;

''(D) $400,000,000 for fiscal year 2010;

''(E) $450,000,000 for each of fiscal years 2011 through 2016;

''(F) $254,500,000 for fiscal year 2019;

''(G) $337,500,000 for the period beginning on January 1, 2020, and ending on September 30, 2020;

''(H) for the period beginning on October 1, 2020, and ending on December 18, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020;

''(I) for the period beginning on December 19, 2020, and ending on September 30, 2021, the amount equal to the pro rata portion of an annual appropriation of $450,000,000;

''(J) $450,000,000 for fiscal year 2022;

''(K) $450,000,000 for fiscal year 2023; and

''(L) $450,000,000 for each of fiscal years 2024 through 2027.

''(2) AVAILABILITY.—Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30 of the subsequent fiscal year.

''(3) TECHNICAL ASSISTANCE.—In addition to amounts otherwise available, there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated for fiscal 2023 and for each subsequent 3-year period through fiscal year 2029, $5,000,000, to remain available until expended, for carrying out subsections (f) and (g).

''(i) BEST PRACTICES.—

''(1) REPORT.—The Secretary, directly or through grant or contract, shall submit a report to the President and Congress not later than September 30, 2022, that contains findings and conclusions on best practices from MFP demonstration projects carried out with grants made under this section. The report shall include information and analyses with respect to the following:

''(A) The most effective State strategies for transitioning beneficiaries from institutional to qualified community settings carried out under MFP demonstration projects and how such strategies may vary for different types of beneficiaries, such as beneficiaries who are aged, physically disabled, intellectually or developmentally disabled, or individuals with serious mental illnesses, and other targeted waiver beneficiary populations under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)].

''(B) The most common and the most effective State uses of grant funds carried out under demonstration projects for transitioning beneficiaries from institutional to qualified community settings and improving health outcomes, including differentiating funding for current initiatives that are designed for such purpose and funding for proposed initiatives that are designed for such purpose.

''(C) The most effective State approaches carried out under MFP demonstration projects for improving person-centered care and planning.

''(D) Identification of program, financing, and other flexibilities available under MFP demonstration projects, that are not available under the traditional Medicaid program, and which directly contributed to successful transitions and improved health outcomes under MFP demonstration projects.

''(E) State strategies and financing mechanisms for effective coordination of housing financed or supported under MFP demonstration projects with local housing authorities and other resources.

''(F) Effective State approaches for delivering Money Follows the Person transition services through managed care entities.

''(G) Other best practices and effective transition strategies demonstrated by States with approved MFP demonstration projects, as determined by the Secretary.

''(H) Identification and analyses of opportunities and challenges to integrating effective Money Follows the Person practices and State strategies into the traditional Medicaid program.

''(2) COLLABORATION.—In preparing the report required under this subsection, the Secretary shall collect and incorporate information from States with approved MFP demonstration projects and beneficiaries participating in such projects, and providers participating in such projects.

''(3) WAIVER OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to preparation of the report described in paragraph (1) or collection of information described in paragraph (2).

''(4) FUNDING.—From the amounts appropriated under subsection (h)(1) for each of fiscal years 2021 and 2022, not more than $300,000 shall be available to the Secretary for each such fiscal year to carry out this subsection.

''(j) MACPAC REPORT.—Prior to the final implementation date established by the Secretary for the criteria established for home and community-based settings in section 441.301(c)(4) of title 42, Code of Federal Regulations, as part of final implementation of the Home and Community Based Services (HCBS) Final Rule published on January 16, 2014 (79 Fed. Reg. 2947) (referred to in this subsection as the 'HCBS final rule'), the Medicaid and CHIP Payment and Access Commission (MACPAC) shall submit to Congress a report that—

''(1) identifies the types of home and community-based settings and associated services that are available to eligible individuals in both the MFP demonstration program and sites in compliance with the HCBS final rule; and

''(2) if determined appropriate by the Commission, recommends policies to align the criteria for a qualified residence under subsection (b)(6) (as in effect on October 1, 2017) with the criteria in the HCBS final rule.''

[Pub. L. 116–260, div. CC, title II, §204(b)(2), Dec. 27, 2020, 134 Stat. 2980, provided that: ''The amendments made by paragraph (1) [amending section 6071 of Pub. L. 109–171, set out above] shall take effect on the date that is 30 days after the date of the enactment of this Act [Dec. 27, 2020].'']

[Pub. L. 116–39, §4, Aug. 6, 2019, 133 Stat. 1061, which directed amendment of section 6071(h)(1)(F) of Pub. L. 109–171, set out above, by substituting ''$254,500,000'' for ''$132,000,000'', was executed by making the substitution

for ''132,000,000'' to reflect the probable intent of Congress and the amendment by section 5 of Pub. L. 116–16, which struck out the dollar sign.]

[Pub. L. 111–148, title II, §2403(b)(2), Mar. 23, 2010, 124 Stat. 305, provided that: ''The amendments made by this subsection [amending section 6071 of Pub. L. 109–171, set out above] take effect 30 days after the date of enactment of this Act [Mar. 23, 2010].'']

STUDY REGARDING BARRIERS TO PARTICIPATION OF FARMWORKERS IN HEALTH PROGRAMS

Pub. L. 107–251, title IV, §404, Oct. 26, 2002, 116 Stat. 1662, as amended by Pub. L. 108–163, §2(n)(1), Dec. 6, 2003, 117 Stat. 2023, provided that:

''(a) IN GENERAL.—The Secretary shall conduct a study of the problems experienced by farmworkers (including their families) under Medicaid and SCHIP. Specifically, the Secretary shall examine the following:

''(1) BARRIERS TO ENROLLMENT.—Barriers to their enrollment, including a lack of outreach and outstationed eligibility workers, complicated applications and eligibility determination procedures, and linguistic and cultural barriers.

''(2) LACK OF PORTABILITY.—The lack of portability of Medicaid and SCHIP coverage for farmworkers who are determined eligible in one State but who move to other States on a seasonal or other periodic basis.

''(3) POSSIBLE SOLUTIONS.—The development of possible solutions to increase enrollment and access to benefits for farmworkers, because, in part, of the problems identified in paragraphs (1) and (2), and the associated costs of each of the possible solutions described in subsection (b).

''(b) POSSIBLE SOLUTIONS.—Possible solutions to be examined shall include each of the following:

''(1) INTERSTATE COMPACTS.—The use of interstate compacts among States that establish portability and reciprocity for eligibility for farmworkers under the Medicaid and SCHIP and potential financial incentives for States to enter into such compacts.

''(2) DEMONSTRATION PROJECTS.—The use of multistate demonstration waiver projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to develop comprehensive migrant coverage demonstration projects.

''(3) USE OF CURRENT LAW FLEXIBILITY.—Use of current law Medicaid and SCHIP State plan provisions relating to coverage of residents and out-of-State coverage.

''(4) NATIONAL MIGRANT FAMILY COVERAGE.—The development of programs of national migrant family coverage in which States could participate.

''(5) PUBLIC-PRIVATE PARTNERSHIPS.—The provision of incentives for development of public-private partnerships to develop private coverage alternatives for farmworkers.

''(6) OTHER POSSIBLE SOLUTIONS.—Such other solutions as the Secretary deems appropriate.

''(c) CONSULTATIONS.—In conducting the study, the Secretary shall consult with the following:

''(1) Farmworkers affected by the lack of portability of coverage under the Medicaid program or the State children's health insurance program (under titles XIX and XXI of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.]).

''(2) Individuals with expertise in providing health care to farmworkers, including designees of national and local organizations representing migrant health centers and other providers.

''(3) Resources with expertise in health care financing.

''(4) Representatives of foundations and other nonprofit entities that have conducted or supported research on farmworker health care financial issues.

''(5) Representatives of Federal agencies which are involved in the provision or financing of health care to farmworkers, including the Centers for Medicare & Medicaid Services and the Health Resources and Services Administration.

''(6) Representatives of State governments.

''(7) Representatives from the farm and agricultural industries.

''(8) Designees of labor organizations representing farmworkers.

''(d) DEFINITIONS.—For purposes of this section:

''(1) FARMWORKER.—The term 'farmworker' means a migratory agricultural worker or seasonal agricultural worker, as such terms are defined in section 330(g)(3) of the Public Health Service Act (42 U.S.C. 254c(g)(3) [254b(g)(3)]), and includes a family member of such a worker.

''(2) MEDICAID.—The term 'Medicaid' means the program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

''(3) SCHIP.—The term 'SCHIP' means the State children's health insurance program under title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

''(e) REPORT.—Not later than one year after the date of the enactment of this Act [Oct. 26, 2002], the Secretary shall transmit a report to the President and the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Secretary considers appropriate.''

STUDY ON LIMITATION ON STATE PAYMENT FOR MEDICARE COST-SHARING AFFECTING ACCESS TO SERVICES FOR QUALIFIED MEDICARE BENEFICIARIES

Pub. L. 106–554, §1(a)(6) [title I, §125], Dec. 21, 2000, 114 Stat. 2763, 2763A–479, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine if access to certain services (including mental health services) for qualified medicare beneficiaries has been affected by limitations on a State's payment for medicare cost-sharing for such beneficiaries under section 1902(n) of the Social Security Act (42 U.S.C. 1396a(n)). As part of such study, the Secretary shall analyze the effect of such payment limitation on providers who serve a disproportionate share of such beneficiaries.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary shall submit to Congress a report on the study under subsection (a). The report shall include recommendations regarding any changes that should be made to the State payment limits under section 1902(n) for qualified medicare beneficiaries to ensure appropriate access to services.''

GAO STUDY OF FUTURE REBASING

Pub. L. 106–554, §1(a)(6) [title VII, §702(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, provided that: ''The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the medicaid program for services provided by Federally-qualified health centers and rural health clinics (as provided under the amendments made by this section [amending this section and sections 1396b and 1396n of this title and repealing provisions set out as a note under this section]). The Comptroller General shall provide for submittal of a report on such study to Congress by not later than 4 years after the date of the enactment of this Act [Dec. 21, 2000].''

GAO REPORTS

Pub. L. 106–170, title II, §201(c), Dec. 17, 1999, 113 Stat. 1893, provided that: ''Not later than 3 years after the date of the enactment of this Act [Dec. 17, 1999], the Comptroller General of the United States shall submit a report to the Congress regarding the amendments made by this section [amending this section and sections 1396b, 1396d, and 1396*o* of this title] that examines—

''(1) the extent to which higher health care costs for individuals with disabilities at higher income levels deter employment or progress in employment;

''(2) whether such individuals have health insurance coverage or could benefit from the State option es-

tablished under such amendments to provide a medicaid buy-in; and

''(3) how the States are exercising such option, including—

''(A) how such States are exercising the flexibility afforded them with regard to income disregards;

''(B) what income and premium levels have been set;

''(C) the degree to which States are subsidizing premiums above the dollar amount specified in section 1916(g)(2) of the Social Security Act (42 U.S.C. 1396*o*(g)(2)); and

''(D) the extent to which there exists any crowd-out effect.''

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, provided that: ''Not later than 1 year after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit a report to Congress that evaluates the effect on Federally-qualified health centers and rural health clinics and on the populations served by such centers and clinics of the phase-out and elimination of the reasonable cost basis for payment for Federally-qualified health center services and rural health clinic services provided under section 1902(a)(13)(C)(i) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)(i)), as amended by section 4712 of BBA (111 Stat. 508) [the Balanced Budget Act of 1997, Pub. L. 105–33] and subsection (a) of this section. Such report shall include an analysis of the amount, method, and impact of payments made by States that have provided for payment under title XIX of such Act [42 U.S.C. 1396 et seq.] for such services on a basis other than payment of costs which are reasonable and related to the cost of furnishing such services, together with any recommendations for legislation, including whether a new payment system is needed, that the Comptroller General determines to be appropriate as a result of the study.''

DEMONSTRATION OF COVERAGE UNDER THE MEDICAID PROGRAM OF WORKERS WITH POTENTIALLY SEVERE DISABILITIES

Pub. L. 106–170, title II, §204, Dec. 17, 1999, 113 Stat. 1897, provided that:

''(a) STATE APPLICATION.—A State may apply to the Secretary of Health and Human Services (in this section referred to as the 'Secretary') for approval of a demonstration project (in this section referred to as a 'demonstration project') under which up to a specified maximum number of individuals who are workers with a potentially severe disability (as defined in subsection (b)(1)) are provided medical assistance equal to—

''(1) that provided under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) to individuals described in section 1902(a)(10)(A)(ii)(XIII) of that Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)); or

''(2) in the case of a State that has not elected to provide medical assistance under that section to such individuals, such medical assistance as the Secretary determines is an appropriate equivalent to the medical assistance described in paragraph (1).

''(b) WORKER WITH A POTENTIALLY SEVERE DISABILITY DEFINED.—For purposes of this section—

''(1) IN GENERAL.—The term 'worker with a potentially severe disability' means, with respect to a demonstration project, an individual who—

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

''(B) has a specific physical or mental impairment that, as defined by the State under the demonstration project, is reasonably expected, but for the receipt of items and services described in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), to become blind or disabled (as defined under section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a))); and

''(C) is employed (as defined in paragraph (2)).

''(2) DEFINITION OF EMPLOYED.—An individual is considered to be 'employed' if the individual—

''(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) 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 under the demonstration project and approved by the Secretary.

''(c) APPROVAL OF DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—Subject to paragraph (3), the Secretary shall approve applications under subsection (a) that meet the requirements of paragraph (2) and such additional terms and conditions as the Secretary may require. The Secretary may waive the requirement of section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations.

''(2) TERMS AND CONDITIONS OF DEMONSTRATION PROJECTS.—The Secretary may not approve a demonstration project under this section unless the State provides assurances satisfactory to the Secretary that the following conditions are or will be met:

''(A) MAINTENANCE OF STATE EFFORT.—Federal funds paid to a State pursuant to this section must be used to supplement, but not supplant, the level of State funds expended for workers with potentially severe disabilities under programs in effect for such individuals at the time the demonstration project is approved under this section.

''(B) INDEPENDENT EVALUATION.—The State provides for an independent evaluation of the project.

''(3) LIMITATIONS ON FEDERAL FUNDING.—

''(A) APPROPRIATION.—

''(i) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section—

''(I) $42,000,000 for each of fiscal years 2001 through 2004; and

''(II) $41,000,000 for each of fiscal years 2005 and 2006.

''(ii) BUDGET AUTHORITY.—Clause (i) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under clause (i).

''(B) LIMITATION ON PAYMENTS.—In no case may—

''(i) the aggregate amount of payments made by the Secretary to States under this section exceed $250,000,000;

''(ii) the aggregate amount of payments made by the Secretary to States for administrative expenses relating to annual reports required under subsection (d) exceed $2,000,000 of such $250,000,000; or

''(iii) payments be provided by the Secretary for a fiscal year after fiscal year 2009.

''(C) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to States based on their applications and the availability of funds. Funds allocated to a State under a grant made under this section for a fiscal year shall remain available until expended.

''(D) FUNDS NOT ALLOCATED TO STATES.—Funds not allocated to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for allocation by the Secretary using the allocation formula established under this section.

''(E) PAYMENTS TO STATES.—The Secretary shall pay to each State with a demonstration project approved under this section, from its allocation under subparagraph (C), an amount for each quarter equal to the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1395d(b) [42 U.S.C. 1396d(b)]) of expenditures in the quarter for medical assistance provided to workers with a potentially severe disability.

''(d) ANNUAL REPORT.—A State with a demonstration project approved under this section shall submit an annual report to the Secretary on the use of funds pro-

vided under the grant. Each report shall include enrollment and financial statistics on—

''(1) the total population of workers with potentially severe disabilities served by the demonstration project; and

''(2) each population of such workers with a specific physical or mental impairment described in subsection (b)(1)(B) served by such project.

''(e) RECOMMENDATION.—Not later than October 1, 2004, the Secretary shall submit a recommendation to the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate regarding whether the demonstration project established under this section should be continued after fiscal year 2006.

''(f) STATE DEFINED.—In this section, the term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).''

MEDICAL ASSISTANCE PAYMENTS FOR ELIGIBLE PACE PROGRAM ENROLLEES

Pub. L. 105–277, div. A, § 101(f) [title VII, § 710], Oct. 21, 1998, 112 Stat. 2681–337, 2681–391, provided that: ''For purposes of payments to States for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] from amounts appropriated to carry out such title for fiscal year 1999 and for any subsequent fiscal year, individuals who are PACE program eligible individuals under section 1934 of that Act [42 U.S.C. 1396u–4] and who meet the income and resource eligibility requirements of individuals who are eligible for medical assistance under section 1902(a)(10)(A)(ii)(VI) of that Act [42 U.S.C. 1396a(a)(10)(A)(ii)(VI)] shall be treated as individuals described in such section 1902(a)(10)(A)(ii)(VI) during the period of their enrollment in the PACE program.''

STUDY AND REPORT BY SECRETARY OF HEALTH AND HUMAN SERVICES

Pub. L. 105–33, title IV, § 4711(b), Aug. 5, 1997, 111 Stat. 508, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall study the effect on access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as amended by subsection (a).

''(2) REPORT.—Not later than 4 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.''

DUAL ELIGIBLES; MONITORING PAYMENTS

Pub. L. 105–33, title IV, § 4724(e), Aug. 5, 1997, 111 Stat. 517, provided that: ''The Administrator of the Health Care Financing Administration shall develop mechanisms to improve the monitoring of, and to prevent, inappropriate payments under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in the case of individuals who are dually eligible for benefits under such program and under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.).''

EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT

Pub. L. 105–33, title IV, § 4759, Aug. 5, 1997, 111 Stat. 528, provided that: ''In the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this subtitle [subtitle H (§§ 4701–4759) of title IV of Pub. L. 105–33, enacting sections 1396u–2 and 1396u–3 of this title, amending this section and sections 1308, 1315, 1320a–3, 1320a–7b, 1395i–3, 1395w–4, 1395cc, 1396b, 1396d, 1396e, 1396n, 1396*o*, 1396r, 1396r–4, 1396r–6, 1396r–8, 1396u–2, and 1396v of this title, and repealing section 1396r–7 of this title], 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 these additional requirements 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 [Aug. 5, 1997]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.''

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.

DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE TO CERTAIN LOW-INCOME FAMILIES NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS

Pub. L. 101–508, title IV, § 4745, Nov. 5, 1990, 104 Stat. 1388–199, as amended by Pub. L. 103–66, title XIII, § 13643(a), Aug. 10, 1993, 107 Stat. 647, provided that:

''(a) DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—(A) The Secretary of Health and Human Services (hereafter in this section referred to as the 'Secretary') shall enter into agreements with 3 and no more than 4 States submitting applications under this section for the purpose of conducting demonstration projects to study the effect on access to, and costs of, health care of eliminating the categorical eligibility requirement for medicaid benefits for certain low-income individuals.

''(B) In entering into agreements with States under this section the Secretary shall provide that at least 1 and no more than 2 of the projects are conducted on a substate basis.

''(2) REQUIREMENTS.—(A) The Secretary may not enter into an agreement with a State to conduct a project unless the Secretary determines that—

''(i) the project can reasonably be expected to improve access to health insurance coverage for the uninsured;

''(ii) with respect to projects for which the statewideness requirement has not been waived, the State provides, under its plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], for eligibility for medical assistance for all individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) of section 1902(*l*) of such Act [42 U.S.C. 1396a(*l*)(1)(A), (B), (C), (D)] (based on the State's election of certain eligibility options the highest income standards and, based on the State's waiver of the application of any resource standard);

''(iii) eligibility for benefits under the project is limited to individuals in families with income below 150 percent of the income official poverty line and who are not individuals receiving benefits under title XIX of the Social Security Act;

''(iv) if the Secretary determines that it is cost-effective for the project to utilize employer coverage (as described in section 1925(b)(4)(D) of the Social Security Act [42 U.S.C. 1396r–6(b)(4)(D)]), the project must require an employer contribution and benefits under the State plan under title XIX of such Act will continue to be made available to the extent they are not available under the employer coverage;

''(v) the project provides for coverage of benefits consistent with subsection (b); and

''(vi) the project only imposes premiums, coinsurance, and other cost-sharing consistent with subsection (c).

''(B) The Secretary may waive the requirements of clause (ii) of this paragraph [probably means subparagraph (A)] with respect to those projects described in subparagraph (B) of paragraph (1).

''(3) PERMISSIBLE RESTRICTIONS.—A project may limit eligibility to individuals whose assets are valued below a level specified by the State. For this purpose, any evaluation of such assets shall be made in a manner consistent with the standards for valuation of assets under the State plan under title XIX of the Social Security Act for individuals entitled to assistance under part A of title IV of such Act [42 U.S.C. 601 et seq.]. Nothing in this section shall be construed as requiring a State to provide for eligibility for individuals for months before the month in which such eligibility is first established.

''(4) EXTENSION OF ELIGIBILITY.—A project may provide for extension of eligibility for medical assistance for individuals covered under the project in a manner similar to that provided under section 1925 of the Social Security Act to certain families receiving aid pursuant to a plan of the State approved under part A of title IV of such Act.

''(5) WAIVER OF REQUIREMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may waive such requirements of title XIX of the Social Security Act (except section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)]) as may be required to provide for additional coverage of individuals under projects under this section.

''(B) NONWAIVABLE PROVISIONS.—Except with respect to those projects described in subparagraph (B) of paragraph (1), the Secretary may not waive, under subparagraph (A), the statewideness requirement of section 1902(a)(1) of the Social Security Act [42 U.S.C. 1396a(a)(1)] or the Federal medical assistance percentage specified in section 1905(b) of such Act [42 U.S.C. 1396d(b)].

''(b) BENEFITS.—

''(1) IN GENERAL.—Except as provided in this subsection, the amount, duration, and scope of medical assistance made available under a project shall be the same as the amount, duration, and scope of such assistance made available to individuals entitled to medical assistance under the State plan under section 1902(a)(10)(A)(i) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)(i)].

''(2) LIMITS ON BENEFITS.—

''(A) REQUIRED.—Except with respect to those projects described in subparagraph (B) of paragraph (1), no medical assistance shall be made available under a project for nursing facility services or community-based long-term care services (as defined by the Secretary) or for pregnancy-related services. No medical assistance shall be made available under a project to individuals confined to a State correctional facility, county jail, local or county detention center, or other State institution.

''(B) PERMISSIBLE.—A State, with the approval of the Secretary, may limit or otherwise deny eligibility for medical assistance under the project and may limit coverage of items and services under the project, other than early and periodic screening, diagnostic, and treatment services for children under 18 years of age.

''(3) USE OF UTILIZATION CONTROLS.—Nothing in this subsection shall be construed as limiting a State's authority to impose controls over utilization of services, including preadmission requirements, managed care provisions, use of preferred providers, and use of second opinions before surgical procedures.

''(c) PREMIUMS AND COST-SHARING.—

''(1) NONE FOR THOSE WITH INCOME BELOW THE POVERTY LINE.—Under a project, there shall be no premiums, coinsurance, or other cost-sharing for individuals whose family income level does not exceed 100 percent of the income official poverty line (as defined in subsection (g)(1)) applicable to a family of the size involved.

''(2) LIMIT FOR THOSE WITH INCOME ABOVE THE POVERTY LINE.—Under a project, for individuals whose family income level exceeds 100 percent, but is less than 150 percent, of the income official poverty line applicable to a family of the size involved, the monthly average amount of premiums, coinsurance, and other cost-sharing for covered items and services shall not exceed 3 percent of the family's average gross monthly earnings.

''(3) INCOME DETERMINATION.—Each project shall provide for determinations of income in a manner consistent with the methodology used for determinations of income under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for individuals entitled to benefits under part A of title IV of such Act [42 U.S.C. 601 et seq.].

''(d) DURATION.—Each project under this section shall commence not later than July 1, 1991 and shall be conducted for a 3-year period; except that the Secretary may terminate such a project if the Secretary determines that the project is not in substantial compliance with the requirements of this section.

''(e) LIMITS ON EXPENDITURES AND FUNDING.—

''(1) IN GENERAL.—(A) The Secretary in conducting projects shall limit the total amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to no more than $40,000,000.

''(B) Of the amounts appropriated under subparagraph (A), the Secretary shall provide that no more than one-third of such amounts shall be used to carry out the projects described in paragraph (1)(B) of subsection (a) (for which the statewideness requirement has been waived).

''(2) NO FUNDING OF CURRENT BENEFICIARIES.—No funding shall be available under a project with respect to medical assistance provided to individuals who are otherwise eligible for medical assistance under the plan without regard to the project.

''(3) NO INCREASE IN FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—Payments to a State under a project with respect to expenditures made for medical assistance made available under the project may not exceed the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act [42 U.S.C. 1396d(b)]) of such expenditures.

''(f) EVALUATION AND REPORT.—

''(1) EVALUATIONS.—For each project the Secretary shall provide for an evaluation to determine the effect of the project with respect to—

''(A) access to, and costs of, health care,

''(B) private health care insurance coverage, and

''(C) premiums and cost-sharing.

''(2) REPORTS.—The Secretary shall prepare and submit to Congress an interim report on the status of the projects not later than January 1, 1993, and a final report containing such summary together with such further recommendations as the Secretary may determine appropriate not later than one year after the termination of the projects.

''(g) DEFINITIONS.—In this section:

''(1) The term 'income official poverty line' means such line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 U.S.C. 9902(2)].

''(2) The term 'project' refers to a demonstration project under subsection (a).''

[Pub. L. 103–66, title XIII, § 13643(a), Aug. 10, 1993, 107 Stat. 647, provided in part that the amendment made by that section to section 4745 of Pub. L. 101–508, set out above, is effective as if included in enactment of Pub. L. 101–508.]

DEMONSTRATION PROJECT TO PROVIDE MEDICAID COVERAGE FOR HIV-POSITIVE INDIVIDUALS

Pub. L. 101–508, title IV, § 4747, Nov. 5, 1990, 104 Stat. 1388–202, provided that:

''(a) IN GENERAL.—Not later than 3 months after the date of the enactment of this Act [Nov. 5, 1990], the

Secretary of Health and Human Services (hereafter in this section referred to as the 'Secretary') shall provide for 2 demonstration projects to be administered by States that submit an application under this section, through programs administered by the States under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]. Such demonstration projects shall provide coverage for the services described in subsection (c) to individuals whose income and resources do not exceed the maximum allowable amount for eligibility for any individual in any category of disability under the State plan under section 1902 of the Social Security Act [42 U.S.C. 1396a], and who have tested positive for the presence of HIV virus (without regard to the presence of any symptoms of AIDS or opportunistic diseases related to AIDS).

''(b) SERVICES AVAILABLE UNDER A DEMONSTRATION PROJECT.—(1) The medical assistance made available to individuals described in section 1902(a)(10)(A) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)] shall be made available to individuals described in subsection (a) who receive services under a demonstration project under such paragraph.

''(2) A demonstration project under subsection (a) shall provide services in addition to the services described in paragraph (1) which shall be limited only on the basis of medical necessity or the appropriateness of such services. To the extent not provided as described in paragraph (1), such additional services shall include—

''(A) general and preventative medical care services (including inpatient, outpatient, residential care, physician visits, clinic visits, and hospice care);

''(B) prescription drugs, including drugs for the purposes of preventative health care services;

''(C) counseling and social services;

''(D) substance abuse treatment services (including services for multiple substances abusers);

''(E) home care services (including assistance in carrying out activities of daily living);

''(F) case management;

''(G) health education services;

''(H) respite care for caregivers;

''(I) dental services; and

''(J) diagnostic and laboratory services[.]

''(c) AGREEMENTS WITH STATES.—(1) Each State conducting a demonstration project under subsection (a) shall enter into an agreement with a hospital and at least one other nonprofit organization submitting applications to the State. The State shall require that such hospital and other entity have a demonstrated record of case management of patients who have tested positive for the presence of HIV virus and have access to a control group of such type of patients who are not receiving State or Federal payments for medical services (or other payments from private insurance coverage) before developing symptoms of AIDS. Under such agreement, the State shall agree to pay each such entity for the services provided under subsection (b) and not later than 12 months after the commencement of a demonstration project, institute a system of monthly payment to each such entity based on the average per capita cost of the services described in subsection (c) provided to individuals described in paragraphs (1) and (2) of subsection (a).

''(2) A demonstration project described in subsection (a) shall be limited to an enrollment of not more than 200 individuals.

''(3) A demonstration project conducted under subsection (a) shall commence not later than 9 months after the date of the enactment of this Act [Nov. 5, 1990] and shall terminate on the date that is 3 years after the date of commencement.

''(4)(A) The Secretary shall provide for an evaluation of the comparative costs of providing services to individuals who have tested positive for the presence of HIV virus at an early stage after detection of such virus and those that are treated at a later stage after such detection.

''(B) The Secretary shall report to Congress on the results of the evaluation conducted under subparagraph (A) no later than 6 months after the date of termination of the demonstration projects described in this section.

''(d) FEDERAL SHARE OF COSTS.—The Federal share of the cost of services described in paragraph (3) furnished under a demonstration project conducted under paragraph (1) shall be determined by the otherwise applicable Federal matching assistance percentage pursuant to section 1905(b) of the Social Security Act [42 U.S.C. 1396d(b)].

''(e) WAIVER OF REQUIREMENTS OF THE SOCIAL SECURITY ACT.—The Secretary may waive such requirements of the Social Security Act [42 U.S.C. 301 et seq.] as the Secretary determines to be necessary to carry out the purposes of this section.

''(f) LIMITATION ON AMOUNT OF EXPENDITURES.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be $5,000,000 for fiscal year 1991, $12,000,000 for fiscal year 1992, and $13,000,000 for fiscal year 1993.''

PUBLIC EDUCATION CAMPAIGN

Pub. L. 101–508, title IV, § 4751(d), Nov. 5, 1990, 104 Stat. 1388–205, provided that:

''(1) IN GENERAL.—The Secretary, no later than 6 months after the date of enactment of this section [Nov. 5, 1990], shall develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient's right to participate and direct health care decisions.

''(2) DEVELOPMENT AND DISTRIBUTION OF INFORMATION.—The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section [amending this section and sections 1396b and 1396r of this title and enacting provisions set out above], to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

''(3) PROVIDING ASSISTANCE TO STATES.—The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

''(4) DUTIES OF SECRETARY.—The Secretary shall mail information to Social Security recipients, [and] add a page to the medicare handbook with respect to the provisions of this section.''

PHYSICIAN IDENTIFIER SYSTEM; DEADLINE AND CONSIDERATIONS

Pub. L. 101–508, title IV, § 4752(a)(1)(B), Nov. 5, 1990, 104 Stat. 1388–206, provided that: ''The system established under the amendment made by subparagraph (A) [amending this section] may be the same as, or different from, the system established under section 9202(g) of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272, formerly set out in a note under section 1395ww of this title].''

FOREIGN MEDICAL GRADUATE CERTIFICATION

Pub. L. 101–508, title IV, § 4752(d), Nov. 5, 1990, 104 Stat. 1388–207, provided that:

''(1) PASSAGE OF FMGEMS EXAMINATION IN ORDER TO OBTAIN IDENTIFIER.—The Secretary of Health and Human Service[s] shall provide, in the identifier system established under section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)], that no foreign medical graduate (as defined in section 1886(h)(5)(D) of such Act [42 U.S.C. 1395ww(h)(5)(D)]) shall be issued an identifier under such system unless the individual—

''(A) has passed the FMGEMS examination (as defined in section 1886(h)(5)(E) of such Act);

''(B) has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates; or

''(C) has held a license from 1 or more States continuously since 1958.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply with respect to issuance of an identifier applicable to services furnished on or after January 1, 1992.''

EXCLUSIONS IN DETERMINATION OF INCOME AND RESOURCES UNDER THIS SUBCHAPTER

Pub. L. 101–508, title XI, §11115(c), Nov. 5, 1990, 104 Stat. 1388–415, provided that: ''Pursuant to section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)), the Secretary of Health and Human Services shall promulgate regulations to exempt from any determination of income and resources (for the month of receipt and the following month) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] any refund of Federal income taxes made to an individual by reason of section 32 of the Internal Revenue Code of 1986 [26 U.S.C. 32] (relating to earned income tax credit), and any payment made to an individual by an employer under [former] section 3507 of such Code [26 U.S.C. 3507] (relating to advance payment of earned income credit).''

DEVELOPMENT OF MODEL APPLICATIONS FOR MEDICAID PROGRAM

Pub. L. 101–239, title VI, §6506(b), Dec. 19, 1989, 103 Stat. 2282, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall, by not later than 1 year after the date of the enactment of this Act [Dec. 19, 1989], develop a model application form for use in applying for benefits under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for individuals who are not receiving cash assistance under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.], and who are not institutionalized. In developing such model application form, the Secretary is not authorized to require that such form be adopted by States as part of their State medicaid plan.

''(2) DISSEMINATION OF MODEL FORM.—The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1), and shall send a copy of such form to each State agency responsible for administering a State medicaid plan.''

CLARIFICATION OF FEDERAL FINANCIAL PARTICIPATION FOR CASE-MANAGEMENT SERVICES

Pub. L. 100–647, title VIII, §8435, Nov. 10, 1988, 102 Stat. 3805, provided that: ''The Secretary of Health and Human Services may not fail or refuse to approve an amendment to a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] that provides for coverage of case-management services described in section 1915(g)(2) of such Act [42 U.S.C. 1396n(g)(2)], or to deny payment to a State for such services under section 1903(a)(1) of such Act [42 U.S.C. 1396b(a)(1)] on the basis that a State is required to provide such services under State law or on the basis that the State had paid or is paying for such services from non-Federal funds before or after April 7, 1986. Nothing in this section shall be construed as requiring the Secretary to make payment to a State under section 1903(a)(1) of such Act for such case-management services which are provided without charge to the users of such services.''

TREATMENT OF STATES OPERATING UNDER DEMONSTRATION PROJECTS

Pub. L. 100–360, title III, §301(g)(1), July 1, 1988, 102 Stat. 750, provided that: ''In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act [42 U.S.C. 1315(a)], the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act [42 U.S.C. 1396a(a)(10)(E)] in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.].''

ADJUSTMENT IN MEDICAID PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

Pub. L. 100–203, title IV, §4112, Dec. 22, 1987, 101 Stat. 1330–148, which related to adjustment in medicaid payment for inpatient hospital services furnished by disproportionate share hospitals was amended by Pub. L. 100–360, title IV, §411(k)(6)(A)–(B)(i), July 1, 1988, 102 Stat. 792, 793, and so amended, §4112 enacts the provisions of former section 4112 as section 1396r–4 of this title and amends sections 1396b and 1396s of this title.

AMENDMENT TO STATE PLAN TO PROVIDE ADJUSTMENT FOR SERVICES FURNISHED DURING FISCAL YEAR 1990

Pub. L. 100–203, title IV, §4211(b)(2), Dec. 22, 1987, 101 Stat. 1330–203, as amended by Pub. L. 101–508, title IV, §4801(e)(1)(B), Nov. 5, 1990, 104 Stat. 1388–215, provided that: ''A plan of a State under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall not be considered to have met the requirement of section 1902(a)(13)(A) of the Social Security Act [42 U.S.C. 1396a(a)(13)(A)] (as amended by paragraph (1)(A) of this subsection), as of the first day of a Federal fiscal year (beginning on or after October 1, 1990), unless the State has submitted to the Secretary of Health and Human Services, as of April 1 before the fiscal year, an amendment to such State plan to provide for an appropriate adjustment in payment amounts for nursing facility services furnished during the Federal fiscal year. Each such amendment shall include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services. The Secretary shall, not later than September 30 before the fiscal year concerned, review each such plan amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement. The absence of approval of such a plan amendment does not relieve the State or any nursing facility of any obligation or requirement under title XIX of the Social Security Act (as amended by this Act).''

TECHNICAL ASSISTANCE WITH RESPECT TO FACILITIES THAT TAKE INTO ACCOUNT CASE MIX OF RESIDENTS

Pub. L. 100–203, title IV, §4211(j), Dec. 22, 1987, 101 Stat. 1330–207, provided that: ''The Secretary of Health and Human Services shall, upon request by a State, furnish technical assistance with respect to the development and implementation of reimbursement methods for nursing facilities that take into account the case mix of residents in the different facilities.''

STATE UTILIZATION REVIEW SYSTEMS

Pub. L. 99–509, title IX, §9432, Oct. 21, 1986, 100 Stat. 2066, as amended by Pub. L. 100–203, title IV, §4118(p)(11), as added by Pub. L. 100–360, title IV, §411(k)(10)(M), July 1, 1988, 102 Stat. 797; Pub. L. 101–508, title IV, §4755(b), Nov. 5, 1990, 104 Stat. 1388–210, provided that:

''(a) IN GENERAL.—(1) The Secretary of Health and Human Services (in this section referred to as the 'Secretary') may not publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to include a program requiring second surgical opinions or a program of inpatient hospital preadmission review.

''(2) The Secretary may not, during the period beginning on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 [Nov. 5, 1990] and end-

ing on the date that is 180 days after the date on which the report required by subsection (d) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to include a program for ambulatory surgery, preadmission testing, or same-day surgery.

''(b) REPORT.—

''(1) The Secretary shall report to Congress, by not later than October 1, 1988, for each State in a representative sample of States—

''(A) the identity of those procedures which are high volume or high cost procedures among patients who are covered under the State medicaid plan,

''(B) the payment rates under those plans for such procedures, and the aggregate annual payment amounts made under such plans for such procedures (including the Federal share of such payment amounts),

''(C) the rate at which each such procedure is performed on medicaid patients and (to the extent that data are available) comparisons to the rate at which such procedure is performed on patients of comparable age who are not medicaid patients,

''(D) with respect to each such procedure—

''(i) the number of board certified or board eligible physicians in the State who provide care and services to medicaid patients and who perform the procedure, and

''(ii) in the case of a State with a mandatory second surgical opinion program in operation, the number of physicians described in clause (i) who provide second opinions (of the type described in section 1164 of the Social Security Act [42 U.S.C. 1320c–13]) for the procedure at prevailing payment rates under the State medicaid plan, and

''(E) in the case of a State with a mandatory second surgical opinion program or a program of inpatient hospital preadmission review in operation, a description of—

''(i) the extent to which such program impedes access to necessary care and services, and

''(ii) the measures that the State has taken to address such impediments, particularly in rural areas.

''(2) Such report shall also include a list of those surgical procedures which the Secretary believes meet the following criteria and for which a mandatory second opinion program under medicaid plans may be appropriate:

''(A) The procedure is one which generally can be postponed without undue risk to the patient.

''(B) The procedure is a high volume procedure among patients who are covered under State medicaid plans or is a high cost procedure.

''(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why requiring second opinions for 100 percent of such procedures would be cost effective.

''(3) The representative sample of States required to be included in the report shall include States with mandatory second surgical opinion programs in operation, States with programs of inpatient hospital preadmission review in operation, and States with neither such program in operation.

''(4) In this subsection and subsection (d), the term 'medicaid plan' means a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

''(c) STUDY.—

''(1) The Secretary shall conduct a study of the utilization of selected medical treatments and surgical procedures by medicaid beneficiaries in order to assess the appropriateness, necessity, and effectiveness of such treatments and procedures.

''(2) The study shall analyze the extent to which there is significant variation in the rate of utilization by medicaid beneficiaries of selected treatments and procedures for different geographic areas within States and among States.

''(3) The study shall also identify underutilized, medically necessary treatments and procedures for which—

''(A) a failure to furnish could have an adverse effect on health status, and

''(B) the rate of utilization by medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

''(4) The study shall be coordinated, to the extent practicable, with the research program established pursuant to section 1875(c) of the Social Security Act [42 U.S.C. 1395*ll*(c)], with particular regard to the relationship of the variations described in paragraph (2) to patient outcomes.

''(5) The Secretary shall submit an interim report on the results of the study, including an analysis of the geographic variations under paragraph (2), to the Congress not later than January 1, 1990, and shall report the final results of the study to the Congress not later than January 1, 1992.

''(d) REPORT.—The Secretary shall report to Congress, by not later than January 1, 1993, for each State in a representative sample of States—

''(1) an analysis of the procedures for which programs for ambulatory surgery, preadmission testing, and same-day surgery are appropriate for patients who are covered under the State medicaid plan, and

''(2) the effects of such programs on access of such patients to necessary care, quality of care, and costs of care.

In selecting such a sample of States, the Secretary shall include some States with medicaid plans that include such programs.''

STUDY BY COMPTROLLER GENERAL OF EFFECT OF AMENDMENT TO SUBSECTION (a)(13)

Pub. L. 99–272, title IX, § 9509(c), Apr. 7, 1986, 100 Stat. 212, directed Comptroller General to conduct a study of effects of the amendments made by this section and report results of such study to Congress two years after Apr. 7, 1986.

TASK FORCE ON TECHNOLOGY-DEPENDENT CHILDREN

Pub. L. 99–272, title IX, § 9520, Apr. 7, 1986, 100 Stat. 217, directed Secretary of Health and Human Services, within six months after Apr. 7, 1986, to establish a task force concerning alternatives to institutional care for technology-dependent children, such task force to (1) include representatives of Federal and State agencies with responsibilities relating to child health, health insurers, large employers (including those that self-insure for health care costs), providers of health care to technology-dependent children, and parents of technology-dependent children, (2) identify barriers that prevent the provision of appropriate care in a home or community setting to meet special needs of technology-dependent children, (3) recommend changes in the provision and financing of health care in private and public health care programs (including appropriate joint public-private initiatives) so as to provide home and community-based alternatives to the institutionalization of technology-dependent children, and (4) make a final report to Secretary and to Congress on its activities not later than two years after Apr. 7, 1986.

MEDICAID COVERAGE RELATING TO ADOPTION ASSISTANCE AGREEMENTS ENTERED INTO BEFORE APRIL 7, 1986

Pub. L. 99–272, title IX, § 9529(b)(2), Apr. 7, 1986, 100 Stat. 220, provided that: ''In the case of an adoption assistance agreement (other than an agreement under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.]) entered into before the date of the enactment of this Act [Apr. 7, 1986]—

''(A) the requirements of subdivisions (aa) and (bb) of section 1902(a)(10)(A)(ii)(VIII) of the Social Secu-

rity Act [42 U.S.C. 1396a(a)(10)(A)(ii)(VIII)(aa), (bb)] shall be deemed to be met if the State agency responsible for adoption assistance agreements determines that—

''(i) at the time of adoptive placement the child had special needs for medical or rehabilitative care that made the child difficult to place; and

''(ii) there is in effect with respect to such child an adoption assistance agreement between the State and an adoptive parent or parents; and

''(B) the requirement of subdivision (cc) of such section shall be deemed to be met if the child was found by the State to be eligible for medical assistance prior to such agreement being entered into.''

PAYMENT FOR PSYCHIATRIC HOSPITAL SERVICES

Pub. L. 98–369, div. B, title III, §2366, July 18, 1984, 98 Stat. 1108, provided that: ''The provisions of section 1902(a)(13) of the Social Security Act [42 U.S.C. 1396a(a)(13)], in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985, and such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987, shall be one-third and two-thirds, respectively, of the amount of the reduction which would have been made without regard to this section.''

MORATORIUM ON REGULATORY ACTIONS BY SECRETARY

Pub. L. 98–369, div. B, title III, §2373(c), July 18, 1984, 98 Stat. 1112, as amended by Pub. L. 100–93, §9, Aug. 18, 1987, 101 Stat. 695, provided that:

''(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to the moratorium period described in paragraph (2) by reason of such State's plan described in paragraph (5) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any part of the plan operating pursuant to section 1902(f) of such Act [42 U.S.C. 1396a(f)]), or the operation thereunder, being determined to be in violation of clause (IV), (V), or (VI) of section 1902(a)(10)(A)(ii) or section 1902(a)(10)(C)(i)(III) of such Act on account of such plan's (or its operation) having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section, provided that such plan (or its operation) does not make ineligible any individual who would be eligible but for the provisions of this subsection.

''(2) The moratorium period is the period beginning on October 1, 1981, and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

''(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act [July 18, 1984] with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

''(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.

''(5) In this subsection, a State plan is considered to include—

''(A) any amendment or other change in the plan which is submitted by a State, or

''(B) any policy or guideline delineated in the Medicaid operation or program manuals of the State which are submitted by the State to the Secretary,

whether before or after the date of enactment of this Act [July 18, 1984] and whether or not the amendment or change, or the operating or program manual was approved, disapproved, acted upon, or not acted upon by the Secretary.

''(6) During the moratorium period, the Secretary shall implement (and shall not change by any administrative action) the policy in effect at the beginning of such moratorium period with respect to—

''(A) the point in time at which an institutionalized individual must sell his home (in order that it not be counted as a resource); and

''(B) the time period allowed for sale of a home of any such individual,

who is an applicant for or recipient of medical assistance under the State plan as a medically needy individual (described in section 1902(a)(10)(C) of the Social Security Act [42 U.S.C. 1396a(a)(10)(C)]) or as an optional categorically needy individual (described in section 1902(a)(10)(A)(ii) of such Act).''

[Amendment of section 2373(c) of Pub. L. 98–369, set out above, by section 9 of Pub. L. 100–93 applicable as though originally included in Pub. L. 98–369, §2373(c), see section 15(e) of Pub. L. 100–93, set out as an Effective Date of 1987 Amendment note under section 1320a–7 of this title.]

EVALUATION AND STUDY OF REASONS FOR TERMINATION BY MEDICAID BENEFICIARIES OF MEMBERSHIP IN HEALTH MAINTENANCE ORGANIZATIONS

Pub. L. 97–35, title XXI, §2178(d), Aug. 13, 1981, 95 Stat. 815, directed Secretary of Health and Human Services to conduct a study evaluating extent of, and reasons for, termination by medicaid beneficiaries of their memberships in health maintenance organizations, placing special emphasis on quantity and quality of medical care provided in health maintenance organizations and quality of such care when provided on a fee-for-service basis, with Secretary to submit an interim report to Congress, within two years after Aug. 13, 1981, and a final report within five years from such date containing, respectively, the interim and final findings and conclusions made as a result of such study.

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

Pub. L. 96–272, title III, §310(b)(1), June 17, 1980, 94 Stat. 533, provided that:

''(A) For purposes of section 1902(a)(10)(A) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)], any individual who, prior to the date of enactment of this Act [June 17, 1980] and for the month of December 1978, was eligible for and received aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], or was eligible for and received supplemental security income benefits under title XVI of such Act [42 U.S.C. 1381 et seq.] (or a supplementary payment described in section 13(c) of Public Law 93–233) [set out as a note under this section], and was also in receipt of (or was a dependent, for purposes of chapter 15 of title 38, United States Code, as in effect on December 31, 1978, of an individual in receipt of) pension from the Veterans' Administration for the month of December 1978 shall (subject to subparagraph (B)) be deemed to have been receiving such aid, assistance, supplemental security income, or supplementary payment, for each calendar month thereafter (prior to the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B)), if such individual would have been eligible therefor in December 1978 and in the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B) had the increase in income of such individual (or of the family of which such individual is a member), attributable to an election (made by such individual or another member of such individual's family) under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [section 306 of Pub. L. 95–588, set out as a note under section 521 of Title 38, Veterans' Benefits], not occurred.

''(B)(i) The provisions of subparagraph (A) shall take effect on January 1, 1979, and shall cease to be effective, in the case of any individual, for and after the first calendar month beginning more than 10 days after an 'informed election' (as defined in subdivision (ii) of this subparagraph) has been made by such individual (or, if such individual is not eligible to make such an election, by a member of such individual's family who is eligible to make such an election which affects such individual's eligibility for aid, assistance, or benefits under a plan or program referred to in subparagraph (A)).

''(ii) The term 'informed election' means an election made under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [section 306 of Pub. L. 95–588, set out as a note under section 521 of Title 38] (or a reaffirmation of such an election which previously was made under such section 306) after the date of compliance by the Administrator of Veterans' Affairs (hereinafter in this section referred to as the 'Administrator') with the provisions of paragraph (2)(A) with respect to the individual concerned. An individual who fails, within the time limits prescribed in paragraph (2)(B), to disaffirm an election previously made by such individual under such section 306 shall be deemed, for purposes of this section and such section 306, to have reaffirmed such election.''

PRESERVATION OF MEDICAID ELIGIBILITY FOR INDIVIDUALS WHO CEASE TO BE ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME BENEFITS ON ACCOUNT OF COST-OF-LIVING INCREASES IN SOCIAL SECURITY BENEFITS

Pub. L. 94–566, title V, § 503, Oct. 20, 1976, 90 Stat. 2685, provided that: ''In addition to other requirements imposed by law as a condition for the approval of any State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], there is hereby imposed the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual, for any month after June 1977 for which such individual is entitled to a monthly insurance benefit under title II of such Act [42 U.S.C. 401 et seq.] but is not eligible for benefits under title XVI of such Act [42 U.S.C. 1381 et seq.], in like manner and subject to the same terms and conditions as are applicable under such State plan in the case of individuals who are eligible for and receiving benefits under such title XVI for such month, if for such month such individual would be (or could become) eligible for benefits under such title XVI except for amounts of income received by such individual and his spouse (if any) which are attributable to increases in the level of monthly insurance benefits payable under title II of such Act [42 U.S.C. 401 et seq.] which have occurred pursuant to section 215(i) of such Act [42 U.S.C. 415(i)], in the case of such individual, since the last month after April 1977 for which such individual was both eligible for (and received) benefits under such title XVI [42 U.S.C. 1381 et seq.] and was entitled to a monthly insurance benefit under such title II [42 U.S.C. 401 et seq.], and, in the case of such individual's spouse (if any), since the last such month for which such spouse was both eligible for (and received) benefits under such title XVI [42 U.S.C. 1381 et seq.] and was entitled to a monthly insurance benefit under such title II [42 U.S.C. 401 et seq.]. Solely for purposes of this section, payments of the type described in section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)] or of the type described in section 212(a) of Public Law 93–66 [set out as note under section 1382 of this title] shall be deemed to be benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].''

MEDICAID ELIGIBILITY FOR INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTARY PAYMENTS; EFFECTIVE DATE

Pub. L. 93–233, § 13(c), Dec. 31, 1973, 87 Stat. 965, provided that: ''In addition to other requirements imposed by law as conditions for the approval of any State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], there is hereby imposed (effective January 1, 1974) the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual—

''(1) for any month for which there (A) is payable with respect to such individual a supplementary payment pursuant to an agreement entered into between the State and the Secretary of Health, Education, and Welfare [now Health and Human Services] under section 212(a) of Public Law 93–66 [set out as note under section 1382 of this title], and (B) would be payable with respect to such individual such a supplementary payment, if the amount of the supplementary payments payable pursuant to such agreement were established without regard to paragraph (3)(A)(ii) of such section 212(a) [set out as note under section 1382 of this title], and

''(2) in like manner, and subject to the same terms and conditions, as medical assistance is provided under such plan to individuals with respect to whom benefits are payable for such month under the supplementary security income program established by title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

Federal matching under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall be available for the medical assistance furnished to individuals who are eligible for such assistance under this subsection.''

COVERAGE OF ESSENTIAL PERSONS UNDER MEDICAID

Pub. L. 93–66, title II, § 230, July 9, 1973, 87 Stat. 159, provided that: ''In the case of any State plan (approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) which for December 1973 provided medical assistance to persons described in section 1905(a)(vi) of such Act [42 U.S.C. 1396d(a)(vi)], there is hereby imposed the requirement (and such State plan shall be deemed to require) that medical assistance under such plan be provided to each such person (who for December 1973 was eligible for medical assistance under such plan) for each month (after December 1973) that—

''(1) the individual (referred to in the last sentence of section 1905(a) of such Act [42 U.S.C. 1396d(a)]) with whom such person is living continues to meet the criteria (as in effect for December 1973) for aid or assistance under a State plan (referred to in such sentence), and

''(2) such person continues to have the relationship with such individual described in such sentence and meets the other criteria (referred to in such sentence) with respect to a State plan (so referred to) as such plan was in effect for December 1973.

Federal matching under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.''

PERSONS IN MEDICAL INSTITUTIONS

Pub. L. 93–66, title II, § 231, July 9, 1973, 87 Stat. 159, as amended by Pub. L. 93–233, § 13(b)(1), Dec. 31, 1973, 87 Stat. 964, provided that: ''For purposes of section 1902(a)(10) of the Social Security Act [42 U.S.C. 1396a(a)(10)], any individual who, for all (or any part of) the month of December 1973—

''(1) was an inpatient in an institution qualified for reimbursement under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], and

''(2)(A) received or would (except for his being an inpatient in such institution) have been eligible to receive aid or assistance under a State plan approved under title I, X, XIV, or XVI of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], and

''(B), [sic] on the basis of his status as described in subparagraph (A), was included as an individual eligible for medical assistance under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] (whether or not such individual actually received aid or assistance under a State plan referred to in subparagraph (A)),

shall be deemed to be receiving such aid or assistance for such month and for each succeeding month in a continuous period of months if, for each month in such period—

''(3) such individual continues to be (for all of such month) an inpatient in such an institution and would (except for his being an inpatient in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

''(4) such individual is determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) to be in need of care in such an institution.

Federal matching under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.''

BLIND AND DISABLED MEDICALLY INDIGENT PERSONS

Pub. L. 93–66, title II, §232, July 9, 1973, 87 Stat. 160, as amended by Pub. L. 93–233, §13(b)(2), Dec. 31, 1973, 87 Stat. 964, provided that: ''For purposes of section 1902(a)(10) of the Social Security Act [42 U.S.C. 1396a(a)(10)], any individual who, for the month of December 1973 was eligible [42 U.S.C. 1396a(a)(10)] for medical assistance by reason of his having been determined to meet the criteria for blindness or disability (established by a State plan approved under title I, X, XIV, or XVI of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.]), shall be deemed for purposes of title XIX [42 U.S.C. 1396 et seq.] to be an individual who is blind or disabled within the meaning of section 1614(a) of the Social Security Act [42 U.S.C. 1382c(a)] for each month in a continuous period of months (beginning with the month of January 1974), if, for each month in such period, such individual continues to meet the criteria for blindness or disability so established by such a State plan (as it was in effect for December 1973), and the other conditions of eligibility contained in the plan of the State approved under title XIX [42 U.S.C. 1396 et seq.] (as it was in effect in December 1973). Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.''

IMPACT OF 1972 SOCIAL SECURITY BENEFITS INCREASE UNDER PUB. L. 92–336 UPON ELIGIBILITY FOR ASSISTANCE UNDER THIS SUBCHAPTER

Pub. L. 92–603, title II, §249E, Oct. 30, 1972, 86 Stat. 1429, as amended by Pub. L. 93–66, title II, §233, July 9, 1973, 87 Stat. 160, provided that: ''For purposes of section 1902(a)(10) of the Social Security Act [42 U.S.C. 1396a(a)(10)] any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.] and who for such month was entitled to monthly insurance benefits under title II of such Act [42 U.S.C. 401 et seq.] shall be deemed to be eligible for such aid or assistance for any month thereafter prior to July 1975 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act [42 U.S.C. 401 et seq.] resulting from enactment of Pub. L. 92–336 [see Tables] not been applicable to such individual.''

NURSING HOMES ELIGIBLE FOR MATCHING FUNDS FOR HOME SERVICES WHEN MEETING STATE LICENSURE REQUIREMENTS AFTER JUNE 30, 1968

Pub. L. 90–248, title II, §234(c), Jan. 2, 1968, 81 Stat. 907, provided that: ''Notwithstanding any other provision of law, after June 30, 1968, no Federal funds shall be paid to any State as Federal matching under title I, X, XIV, XVI, or XIX of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 1396 et seq.] for payments made to any nursing home for or on account of any nursing home services provided by such nursing home for any period during which such nursing home is determined not to meet fully all requirements of the State for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which has formerly met such requirements will be eligible for payments which include Federal participation if during such period or periods such home promptly takes all necessary steps to again meet such requirements.''

DISTRICT OF COLUMBIA; PLAN FOR MEDICAL ASSISTANCE

Pub. L. 90–227, §1, Dec. 27, 1967, 81 Stat. 744, provided: ''That (a) the Commissioner of the District of Columbia [now Mayor] (hereafter in this Act [enacting this note and provisions set out as a note under section 1395v of this title] referred to as the 'Commissioner') may submit under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to the Secretary of Health, Education, and Welfare [now Health and Human Services] (hereafter in this Act referred to as the 'Secretary') a plan for medical assistance (and any modifications of such plan) to enable the District of Columbia to receive Federal financial assistance under such title for a medical assistance program established by the Commissioner under such plan.

''(b)(1) Notwithstanding any other provision of law, the Commissioner may take such action as may be necessary to submit such plan to the Secretary and to establish and carry out such medical assistance program, except that in prescribing the standards for determining eligibility for and the extent of medical assistance under the District of Columbia's plan for medical assistance, the Commissioner may not (except to the extent required by title XIX of the Social Security Act [42 U.S.C. 1396 et seq.])—

''(A) prescribe maximum income levels for recipients of medical assistance under such plan which exceed (i) the title XIX maximum income levels if such levels are in effect, or (ii) the Commissioner's maximum income levels for the local medical assistance program if there are no title XIX maximum income levels in effect; or

''(B) prescribe criteria which would permit an individual or family to be eligible for such assistance if such individual or family would be ineligible, solely by reason of his or its resources, for medical assistance both under the plan of the State of Maryland approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and under the plan of the State of Virginia approved under such title.

''(2) For purposes of subparagraph (A) of paragraph (1) of this subsection—

''(A) the term 'title XIX maximum income levels' means any maximum income levels which may be specified by title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for recipients of medical assistance under State plans approved under that title;

''(B) the term 'the Commissioner's maximum income levels for the local medical assistance program' means the maximum income levels prescribed for recipients of medical assistance under the District of Columbia's medical assistance program in effect in the fiscal year ending June 30, 1967; and

''(C) during any of the first four calendar quarters in which medical assistance is provided under such plan there shall be deemed to be no title XIX maximum income levels in effect if the title XIX maximum income levels in effect during such quarter are higher than the Commissioner's maximum income levels for the local medical assistance program.''

§ 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this sec-

tion) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (j) of this section and section 1396r–4(f) of this title) of the total amount expended during such quarter as medical assistance under the State plan; plus

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

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1396r(e)(1) of this title (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1396r(e)(7) of this title; plus

(D) for each calendar quarter during—

(i) fiscal year 1991, an amount equal to 90 percent,

(ii) fiscal year 1992, an amount equal to 85 percent,

(iii) fiscal year 1993, an amount equal to 80 percent, and

(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1396r(g) of this title; plus

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this subchapter by, children of families for whom English is not the primary language; plus

(3) an amount equal to—

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

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

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization[1] or by an entity which meets the requirements of section 1320c–1 of this title, as determined by the

[1] So in original. Probably should be ''a quality improvement organization''.

Secretary, under a contract entered into under section 1396a(d) of this title; and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1396u–2(c)(2) of this title; and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1396r–8(g) of this title;

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this subchapter and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this subchapter and who have Sickle Cell Disease; and

(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(H)(i)[2] 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1396a(ee) of this title (including a system described in paragraph (2)(B) thereof),[3] and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies,[3] plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title; plus

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

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1396r(g)(3)(B) of this title, an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title.

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1320a–1 of this title.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) $125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this subchapter.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this subchapter shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this subchapter) that provide coverage of services in the same State

[2] So in original. There is no subpar. (G).

[3] So in original. The comma probably should be a semicolon.

in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this subchapter or subchapter XVIII or debarred by any Federal agency, or subject to a civil money penalty under this chapter.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in subsection (w)(3)(A))[4] that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Treatment of educationally-related services

Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [20 U.S.C. 1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act [20 U.S.C. 1431 et seq.].

(d) Estimates of State entitlement; installments; adjustments to reflect overpayments or underpayments; time for recovery or adjustment; uncollectable or discharged debts; obligated appropriations; disputed claims

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1316(d) of this title,

[4] See References in Text note below.

and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1396r–4(c) of this title during such fiscal year.

(e) Transition costs of closures or conversions permitted

A State plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1395uu of this title.

(f) Limitation on Federal participation in medical assistance

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

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

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

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

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1396*o* of this title at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

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

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII), 1396a(a)(10)(A)(i)(VIII), 1396a(a)(10)(A)(i)(IX), 1396a(a)(10)(A)(ii)(IX), 1396a(a)(10)(A)(ii)(X), 1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV), or[5] 1396a(a)(10)(A)(ii)(XV), 1396a(a)(10)(A)(ii)(XVI), 1396a(a)(10)(A)(ii)(XVII), 1396a(a)(10)(A)(ii)(XVIII), 1396a(a)(10)(A)(ii)(XIX), 1396a(a)(10)(A)(ii)(XX), 1396a(a)(10)(A)(ii)(XXI), 1396a(a)(10)(A)(ii)(XXII), 1396d(p)(1) of this title or for any individual—

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

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive

[5] So in original. The word ''or'' probably should precede ''1396d(p)(1)''.

such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, or who is a PACE program eligible individual enrolled in a PACE program under section 1396u–4 of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title,

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

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e–9(d)[4] of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the

State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(h) Repealed. Pub. L. 100–203, title IV, § 4211(g)(1), Dec. 22, 1987, 101 Stat. 1330–205

(i) Payment for organ transplants; item or service furnished by excluded individual, entity, or physician; other restrictions

Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title;

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1395y(*o*) of this title and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments;

(D) beginning on July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1396a(kk)(8) of this title) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1396a(*ll*) of this title; or

(E) with respect to any amount expended for such an item or service furnished during calendar quarters beginning on or after October 1, 2017, subject to section 1396a(kk)(4)(A)(ii)(II) of this title, within a geographic area that is subject to a moratorium imposed under section 1395cc(j)(7) of this title by a provider or supplier that meets the requirements specified in subparagraph (C)(iii) of such section, during the period of such moratorium; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a

utilization review plan which meets the requirements imposed by section 1395x(k) of this title for purposes of subchapter XVIII; and if such hospital has in effect such a utilization review plan for purposes of subchapter XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this subchapter; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1395x(k) of this title; or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of subchapter XVIII because of section 1395y(c) of this title; or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1395*l*(h) of this title for such tests performed for an individual enrolled under part B of subchapter XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1396r(h) of this title or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this subchapter or subchapter XI or for legal expenses in defense of an exclusion or civil money penalty under this subchapter or subchapter XI if there is no reasonable legal ground for the provider's case; or

(9) with respect to any amount expended for non-emergency transportation authorized under section 1396a(a)(4) of this title, unless the State plan provides for the methods and procedures required under section 1396a(a)(30)(A) of this title; or

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1396r–8 of this title with respect to such drugs or unless section 1396r–8(a)(3) of this title applies,[3]

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1396r–8(k) of this title) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in section 1396r–8(a)(7) of this title, unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section;

(D) with respect to any amount expended for reimbursement to a pharmacy under this subchapter for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this subchapter (other than with respect to a reasonable restocking fee for such drug); and

(E) with respect to any amount expended for a covered outpatient drug for which a suspension under section 1396r–8(c)(4)(B)(ii)(II) of this title is in effect; or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1396a(x) of this title, unless the claim for the services includes the unique physician identifier provided under such system; or

(12) with respect to any amounts expended for—

(A) a vacuum erection system that is not medically necessary; or

(B) the insertion, repair, or removal and replacement of a penile prosthetic implant (unless such insertion, repair, or removal and replacement is medically necessary); or

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1396s of this title; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.]; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this subchapter; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1395x(*o*) of this title and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for pro-

grams to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before December 17, 1999;

(21) with respect to amounts expended for covered outpatient drugs described in section 1396r–8(d)(2)(C) of this title (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and section 1396r–8(d)(2)(K) of this title (relating to drugs when used for treatment of sexual or erectile dysfunction);

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1320b–7(d)(1)(A) of this title to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this subchapter, unless the requirement of section 1396a(a)(46)(B) of this title is met;

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1396r–8(k)(2) of this title) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad;

(24) if a State is required to implement an asset verification program under section 1396w of this title and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan;

(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary);

(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i)[6] other than medical assistance provided through benchmark coverage described in section 1396u–7(b)(1) of this title or benchmark equivalent coverage described in section 1396u–7(b)(2) of this title; or

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1395x(n) of this title and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of subchapter XVIII, including, as applicable, under a competitive acquisition program under section 1395w–3 of this title in an area of the State.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Adjustment of amount

Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1396m of this title.

(k) Technical assistance to States

The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this subchapter.

(*l*) Electronic visit verification system for personal care services and home health care services

(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this subchapter (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2020 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

(A) in the case of personal care services—

(i) for calendar quarters in 2020, by .25 percentage points;

(ii) for calendar quarters in 2021, by .5 percentage points;

(iii) for calendar quarters in 2022, by .75 percentage points; and

(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

(B) in the case of home health care services—

(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

(ii) for calendar quarters in 2025, by .5 percentage points;

[6] Probably means subclause (VIII) of subsection (a)(10)(A)(i) of section 1396a of this title.

(iii) for calendar quarters in 2026, by .75 percentage points; and

(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

(i) is minimally burdensome;

(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

(iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 300jj–19 of this title);

(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of December 13, 2016, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

(i) in the case of personal care services, for calendar quarters in 2020; and

(ii) in the case of home health care services, for calendar quarters in 2023.

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

(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii) in implementing such a system, has encountered unavoidable system delays.

(5) In this subsection:

(A) The term ''electronic visit verification system'' means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

(i) the type of service performed;

(ii) the individual receiving the service;

(iii) the date of the service;

(iv) the location of service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

(B) The term ''home health care services'' means services described in section 1396d(a)(7) of this title provided under a State plan under this subchapter (or under a waiver of the plan).

(C) The term ''personal care services'' means personal care services provided under a State plan under this subchapter (or under a waiver of the plan), including services provided under section 1396d(a)(24), 1396n(c), 1396n(i), 1396n(j), or 1396n(k) of this title or under a wavier[7] under section 1315 of this title.

(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(m) "Medicaid managed care organization" defined; duties and functions of Secretary; payments to States; reporting requirements; remedies

(1)(A) The term ''medicaid managed care organization'' means a health maintenance organization, an eligible organization with a contract under section 1395mm of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1396a(w) of this title and—

(i) makes services it provides to individuals eligible for benefits under this subchapter accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this subchapter are in no case held liable for debts of the organization in case of the organization's insolvency.

An organization that is a qualified health maintenance organization (as defined in section 300e–9(d)[4] of this title) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations

[7] So in original. Probably should be ''waiver''.

as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 300e–11(a) and (b) of this title.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if—

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term ''control'' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(ii) Repealed. Pub. L. 105–33, title IV, § 4703(a), Aug. 5, 1997, 111 Stat. 495.

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this subchapter and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1396u–2(a)(4) of this title, and (II) provides for notification in accordance with such section of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,[3]

(viii) such contract provides for disclosure of information in accordance with section 1320a–3 of this title and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1395mm(i)(8) of this title;

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1396u–2 of this title; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1396r–8 of this title as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in

order to include in the information submitted by the State to a manufacturer and the Secretary under section 1396r–8(b)(2)(A) of this title, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1396r–8 of this title are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.

(B) Subparagraph (A)[8] except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 254b(d)(1)(A) or 254c(d)(1) of this title,[4] and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title and, to the extent required by section 1396a(a)(10)(D) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,[4] and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this subchapter on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this subchapter on a prepaid risk basis prior to 1970.

(C) to (E) Repealed. Pub. L. 105–33, title IV, § 4703(b)(1)(A), Aug. 5, 1997, 111 Stat. 495.

(F) Repealed. Pub. L. 105–33, title IV, § 4701(d)(2)(B), Aug. 5, 1997, 111 Stat. 494.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least $100,000 under section 254b(d)(1)(A) or 254c(d)(1) of this title[4] or is receiving (and has received during the previous two years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,[4] clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this subchapter and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1396d(t)(3) of this title,

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1396d(t)(3) of this title with the State.

(3) No payment shall be made under this subchapter to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1396u–2(a)(1) of this title) under the State plan under this subchapter (or under a waiver of the plan) unless the State—

(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1396u–2(d)(5) of this title; and

(B) beginning on January 1, 2018, complies with the requirement specified in section 1396u–2(d)(6)(A) of this title.

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 300e–9(d)[4] of this title) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 300e–17(b) of this title), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

[8] So in original. Probably should be followed by a comma.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this subchapter;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection, or

(II) to an individual or to any other entity under this subsection,[3] or

(v) fails to comply with the requirements of section 1395mm(i)(8) of this title,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6)(A) For purposes of this subsection and section 1396a(e)(2)(A) of this title, in the case of the State of New Jersey, the term ''contract'' shall be deemed to include an undertaking by the State agency, in the State plan under this subchapter, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this subchapter;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this subchapter for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual reapproval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1396n(b) of this title.

(7) Payment shall be made under this subchapter to a State for expenditures for capitation payments described in section 438.6(e) of title 42, Code of Federal Regulations (or any successor regulation).

(8)(A) The State agency administering the State plan under this subchapter may have reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State to the extent the State agency is permitted to access such databases under State law.

(B) Such State agency may facilitate reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State, to same extent that the State agency is permitted under State law to access such databases, for—

(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries; and

(ii) any managed care entity (as defined under section 1396u–2(a)(1)(B) of this title) that has a contract with the State under this subsection or under section 1396d(t)(3) of this title.

(C) Such State agency may share information in such databases, to the same extent that the State agency is permitted under State law to share information in such databases, with—

(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries; and

(ii) any managed care entity (as defined under section 1396u–2(a)(1)(B) of this title) that has a contract with the State under this sub-

section or under section 1396d(t)(3) of this title.

(9)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020, in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1396d(b) of this title (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1396d(y) of this title.

(B) Expenditures described in this subparagraph, with respect to a fiscal year to which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

(I) in the case of a State described in subparagraph (C), to apply a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this subchapter (or a waiver of the plan) that is equal to or greater than 85 percent.

(D) For purposes of this paragraph:

(i) The term ''managed care entity'' means a medicaid managed care organization described in section 1396u–2(a)(1)(B)(i) of this title.

(ii) The term ''minimum medical loss ratio'' means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this subchapter (or a waiver of the plan).

(iii) The term ''other specified entity'' means—

(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).

(n) Repealed. Pub. L. 100–93, § 8(h)(1), Aug. 18, 1987, 101 Stat. 694

(*o*) Restrictions on authorized payments to States

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this subchapter to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 1167(1) of title 29), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) Assignment of rights of payment; incentive payments for enforcement and collection

(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1396k of this title, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) "State medicaid fraud control unit" defined

For the purposes of this section, the term ''State medicaid fraud control unit'' means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this subchapter to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority

or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this subchapter.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this subchapter.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this subchapter; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1320a–7b(f)(1) of this title), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this subchapter.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this subchapter;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities and of patients (who are receiving medical assistance under the State plan under this subchapter (or waiver of such plan)) in a noninstitutional or other setting; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term ''board and care facility'' means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this subchapter) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r) Mechanized claims processing and information retrieval systems; operational, etc., requirements

(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this subchapter, a State must, in addition to meeting the requirements of paragraph (3), have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of subchapter XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this subchapter or subchapter XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under subchapter XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this subchapter or subchapter XVIII; and

(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of subchapter XI;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States.

(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

(A) Not later than September 1, 2010:

(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this subchapter.

(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this subchapter with respect to items or services for which States provide medical assistance under this subchapter and no national correct coding methodologies have been established under such Initiative with respect to subchapter XVIII.

(iii) Notify States of—

(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(II) how States are to incorporate such methodologies into claims filed under this subchapter.

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).

(s) Limitations on certain physician referrals

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in subsection (h)(6) of section 1395nn of this title) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under subchapter XVIII if such subchapter provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this subchapter in the same manner as such subsections apply to a provider of such a service for which payment may be made under such subchapter.

(t) Payments to encourage adoption and use of certified EHR technology

(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection—

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term ''Medicaid provider'' means—

(A) an eligible professional (as defined in paragraph (3)(B))—

(i) who is not hospital-based and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children's hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1395w–4(*o*) and 1395w–23(*l*) of this title with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under subsection (m) or section 1396u–2 of this title).

(3) In this subsection and subsection (a)(3)(F):

(A) The term ''certified EHR technology'' means a qualified electronic health record (as defined in[9] 300jj(13) of this title) that is certified pursuant to section 300jj–11(c)(5) of this title as meeting standards adopted under section 300jj–14 of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term ''eligible professional'' means a—

(i) physician;

(ii) dentist;

(iii) certified nurse mid-wife;

(iv) nurse practitioner; and

(v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term ''average allowable costs'' means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

(i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and

(ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term ''hospital-based'' means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual's professional services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term ''net average allowable costs'' means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term ''needy individual'' means, with respect to a Medicaid provider, an individual—

(i) who is receiving assistance under this subchapter;

(ii) who is receiving assistance under subchapter XXI;

(iii) who is furnished uncompensated care by the provider; or

(iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—

(i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed $25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));

(ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed $10,000; and

(iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid[10] provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be ⅔ of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Sec-

[9] So in original. The word ''section'' probably should appear.

[10] So in original. Probably should be preceded by ''a''.

retary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

(i) in the aggregate the product of—

(I) the overall hospital EHR amount for the provider computed under subparagraph (B); and

(II) the Medicaid share for such provider computed under subparagraph (C);

(ii) in any year 50 percent of the product described in clause (i); and

(iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1395ww(n)(2)(A) of this title for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1395ww(n)(2)(C) of this title for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1395ww(n)(2)(D) of this title for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this subchapter and who are not described in section 1395ww(n)(2)(D)(i) of this title. In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under subsection (m) or section 1396u–2 of this title).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

(ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1395w–4(*o*) or 1395ww(n) of this title.

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall

ensure coordination of payment with respect to such providers under sections 1395w–4(*o*) and 1395w–23(*l*) of this title and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under subchapter XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this subchapter, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u) Limitation of Federal financial participation in erroneous medical assistance expenditures

(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this subchapter exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term ''erroneous excess payments for medical assistance'' means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1396k(a)(1)(C) or 602(a)(26)(C)[4] of this title or with respect to payments made in violation of section 1396e of this title.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1396r–1(b)(1) of this title), for items and services described in subsection (a) of section 1396r–1a of this title provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in

subsection (a) of section 1396r–1b of this title during a presumptive eligibility period under such section, or[11] for medical assistance provided to an individual described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1396a(a)(47)(B) of this title to be a qualified entity for such purpose.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1383c of this title and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this subchapter for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v) Medical assistance to aliens not lawfully admitted for permanent residence

(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2) and (4), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter (other than the requirement of the receipt of aid or assistance under subchapter IV, supplemental security income benefits under subchapter XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term ''emergency medical condition'' means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this subchapter) to provide medical assistance under this subchapter, notwithstanding sections 1611(a), 1612(b), 1613, and 1631 of title 8, to children and pregnant women who are lawfully residing in the United States (including battered individuals described in section 1641(c) of title 8) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) Pregnant women

Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

(ii) Children

Individuals under 21 years of age, including optional targeted low-income children described in section 1396d(u)(2)(B) of this title.

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State's ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with fur-

[11] So in original. The word ''or'' probably should not appear.

ther documentation or other evidence to verify that the individual is lawfully residing in the United States.

(w) Prohibition on use of voluntary contributions, and limitation on use of provider-specific taxes to obtain Federal financial participation under medicaid

(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this subchapter during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term ''impermissible tax'' means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term ''provider-related donation'' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term ''bona fide provider-related donation''

means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this subchapter to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this subchapter and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term ''health care related tax'' means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term ''broad-based health care related tax'' means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this subchapter or subchapter XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this subchapter or subchapter XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this subchapter as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this subchapter for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this subchapter or under subchapter XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this subchapter) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, ''5.5 percent'' shall be substituted for ''6 percent'' each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this subchapter nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term ''State base percentage'' means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of December 12, 1991.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in section 1396a(a)(2) of this title, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

(i) Inpatient hospital services.

(ii) Outpatient hospital services.

(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

(iv) Services of intermediate care facilities for the mentally retarded.

(v) Physicians' services.

(vi) Home health care services.

(vii) Outpatient prescription drugs.

(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term ''health care provider'' means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be ''related'' to a health care provider if the entity—

(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

(ii) is a person with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the provider;

(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

(iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term ''State'' means only the 50 States and the District of Columbia but does not include any State whose entire program under this subchapter is operated under a waiver granted under section 1315 of this title.

(E) The ''State fiscal year'' means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term ''tax'' includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term ''unit of local government'' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

(x) Satisfactory documentary evidence of citizenship or nationality by individual declaring to be citizen or national of United States

(1) For purposes of section 1396a(a)(46)(B)(i) of this title, the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this subchapter—

(A) and is entitled to or enrolled for benefits under any part of subchapter XVIII;

(B) and is receiving—

(i) disability insurance benefits under section 423 of this title or monthly insurance benefits under section 402 of this title based on such individual's disability (as defined in section 423(d) of this title); or

(ii) supplemental security income benefits under subchapter XVI;

(C) and with respect to whom—

(i) child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of subchapter IV;

(D) pursuant to the application of section 1396a(e)(4) of this title (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or

(E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) For purposes of this subsection, the term ''satisfactory documentary evidence of citizenship or nationality'' means—

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

(i) A United States passport.

(ii) Form N–550 or N–570 (Certificate of Naturalization).

(iii) Form N–560 or N–561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver's license or other identity document described in section 1324a(b)(1)(D) of title 8, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

(II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

(vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

(C) The following are documents described in this subparagraph:

(i) A certificate of birth in the United States.

(ii) Form FS–545 or Form DS–1350 (Certification of Birth Abroad).

(iii) Form I–197 (United States Citizen Identification Card).

(iv) Form FS–240 (Report of Birth Abroad of a Citizen of the United States).

(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may

specify that provides proof of United States citizenship or nationality.

(D) The following are documents described in this subparagraph:

(i) Any identity document described in section 1324a(b)(1)(D) of title 8.

(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

(E) A reference in this paragraph to a form includes a reference to any successor form.

(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1396a(a)(46)(B)(i) of this title, the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1320b–7(d)(4)(A) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in subparagraph (A) or (B) of section 1396a(a)(46) of this title, the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1396a(e)(4) of this title that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.

(y) Payments for establishment of alternate non-emergency services providers

(1) Payments

In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1396*o*–1(e)(5)(B)[12] of this title), or networks of such providers.

(2) Limitation

The total amount of payments under this subsection shall not exceed $50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) Preference

In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

(A) serve rural or underserved areas where beneficiaries under this subchapter may not have regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) Form and manner of payment

Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a).

(z) Medicaid transformation payments

(1) In general

In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this subchapter.

(2) Permissible uses of funds

The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

(B) Methods for improving rates of collection from estates of amounts owed under this subchapter.

(C) Methods for reducing waste, fraud, and abuse under the program under this subchapter, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

(D) Implementation of a medication risk management program as part of a drug use review program under section 1396r–8(g) of this title.

(E) Methods in reducing, in clinically appropriate ways, expenditures under this subchapter for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) Application; terms and conditions

(A) In general

No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

(B) Terms and conditions

Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

(C) Annual report

Payment to a State under this subsection is conditioned on the State submitting to

[12] So in original. Probably should be section ''1396*o*–1(e)(4)(B)''.

the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

(i) the specific uses of such payment;

(ii) an assessment of quality improvements and clinical outcomes under such programs; and

(iii) estimates of cost savings resulting from such programs.

(4) Funding

(A) Limitation on funds

The total amount of payments under this subsection shall be equal to, and shall not exceed—

(i) $75,000,000 for fiscal year 2007; and

(ii) $75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(B) Allocation of funds

The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

(C) Form and manner of payment

Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a). There is no requirement for State matching funds to receive payments under this subsection.

(5) Medication risk management program

(A) In general

For purposes of this subsection, the term ''medication risk management program'' means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) Elements

Such program may include the following elements:

(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

(ii) On an ongoing basis provide outlier physicians—

(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician's care; and

(III) applicable best practice guidelines and empirical references.

(iii) Monitor outlier physician's prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) Targeted beneficiaries

For purposes of this paragraph, the term ''targeted beneficiaries'' means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

(aa) Demonstration project to increase substance use provider capacity

(1) In general

Not later than the date that is 180 days after October 24, 2018, the Secretary shall, in consultation, as appropriate, with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, conduct a 54-month demonstration project for the purpose described in paragraph (2) under which the Secretary shall—

(A) for the first 18-month period of such project, award planning grants described in paragraph (3); and

(B) for the remaining 36-month period of such project, provide to each State selected under paragraph (4) payments in accordance with paragraph (5).

(2) Purpose

The purpose described in this paragraph is for each State selected under paragraph (4) to increase the treatment capacity of providers participating under the State plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver) through the following activities:

(A) For the purpose described in paragraph (3)(C)(i), activities that support an ongoing assessment of the behavioral health treatment needs of the State, taking into account the matters described in subclauses (I) through (IV) of such paragraph.

(B) Activities that, taking into account the results of the assessment described in subparagraph (A), support the recruitment, training, and provision of technical assistance for providers participating under the State plan (or a waiver of such plan) that offer substance use disorder treatment or recovery services.

(C) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that—

(i) are authorized to dispense drugs approved by the Food and Drug Administration for individuals with a substance use

disorder who need withdrawal management or maintenance treatment for such disorder; and

(ii) are qualified under applicable State law to provide substance use disorder treatment or recovery services.

(D) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that have the qualifications to address the treatment or recovery needs of—

(i) individuals enrolled under the State plan (or a waiver of such plan) who have neonatal abstinence syndrome, in accordance with guidelines issued by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists relating to maternal care and infant care with respect to neonatal abstinence syndrome;

(ii) pregnant women, postpartum women, and infants, particularly the concurrent treatment, as appropriate, and comprehensive case management of pregnant women, postpartum women and infants, enrolled under the State plan (or a waiver of such plan);

(iii) adolescents and young adults between the ages of 12 and 21 enrolled under the State plan (or a waiver of such plan); or

(iv) American Indian and Alaska Native individuals enrolled under the State plan (or a waiver of such plan).

(3) Planning grants

(A) In general

The Secretary shall, with respect to the first 18-month period of the demonstration project conducted under paragraph (1), award planning grants to at least 10 States selected in accordance with subparagraph (B) for purposes of preparing an application described in paragraph (4)(C) and carrying out the activities described in subparagraph (C).

(B) Selection

In selecting States for purposes of this paragraph, the Secretary shall—

(i) select States that have a State plan (or waiver of the State plan) approved under this subchapter;

(ii) select States in a manner that ensures geographic diversity; and

(iii) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

(C) Activities described

Activities described in this subparagraph are, with respect to a State, each of the following:

(i) Activities that support the development of an initial assessment of the behavioral health treatment needs of the State to determine the extent to which providers are needed (including the types of such providers and geographic area of need) to improve the network of providers that treat substance use disorders under the State plan (or waiver), including the following:

(I) An estimate of the number of individuals enrolled under the State plan (or a waiver of such plan) who have a substance use disorder.

(II) Information on the capacity of providers to provide substance use disorder treatment or recovery services to individuals enrolled under the State plan (or waiver), including information on providers who provide such services and their participation under the State plan (or waiver).

(III) Information on the gap in substance use disorder treatment or recovery services under the State plan (or waiver) based on the information described in subclauses (I) and (II).

(IV) Projections regarding the extent to which the State participating under the demonstration project would increase the number of providers offering substance use disorder treatment or recovery services under the State plan (or waiver) during the period of the demonstration project.

(ii) Activities that, taking into account the results of the assessment described in clause (i), support the development of State infrastructure to, with respect to the provision of substance use disorder treatment or recovery services under the State plan (or a waiver of such plan), recruit prospective providers and provide training and technical assistance to such providers.

(D) Funding

For purposes of subparagraph (A), there is appropriated, out of any funds in the Treasury not otherwise appropriated, $50,000,000, to remain available until expended.

(4) Post-planning states

(A) In general

The Secretary shall, with respect to the remaining 36-month period of the demonstration project conducted under paragraph (1), select not more than 5 States in accordance with subparagraph (B) for purposes of carrying out the activities described in paragraph (2) and receiving payments in accordance with paragraph (5).

(B) Selection

In selecting States for purposes of this paragraph, the Secretary shall—

(i) select States that received a planning grant under paragraph (3);

(ii) select States that submit to the Secretary an application in accordance with the requirements in subparagraph (C), taking into consideration the quality of each such application;

(iii) select States in a manner that ensures geographic diversity; and

(iv) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

(C) Applications

(i) In general

A State seeking to be selected for purposes of this paragraph shall submit to the Secretary, at such time and in such form and manner as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require, in addition to the following:

(I) A proposed process for carrying out the ongoing assessment described in paragraph (2)(A), taking into account the results of the initial assessment described in paragraph (3)(C)(i).

(II) A review of reimbursement methodologies and other policies related to substance use disorder treatment or recovery services under the State plan (or waiver) that may create barriers to increasing the number of providers delivering such services.

(III) The development of a plan, taking into account activities carried out under paragraph (3)(C)(ii), that will result in long-term and sustainable provider networks under the State plan (or waiver) that will offer a continuum of care for substance use disorders. Such plan shall include the following:

(aa) Specific activities to increase the number of providers (including providers that specialize in providing substance use disorder treatment or recovery services, hospitals, health care systems, Federally qualified health centers, and, as applicable, certified community behavioral health clinics) that offer substance use disorder treatment, recovery, or support services, including short-term detoxification services, outpatient substance use disorder services, and evidence-based peer recovery services.

(bb) Strategies that will incentivize providers described in subparagraphs (C) and (D) of paragraph (2) to obtain the necessary training, education, and support to deliver substance use disorder treatment or recovery services in the State.

(cc) Milestones and timeliness for implementing activities set forth in the plan.

(dd) Specific measurable targets for increasing the substance use disorder treatment and recovery provider network under the State plan (or a waiver of such plan).

(IV) A proposed process for reporting the information required under paragraph (6)(A), including information to assess the effectiveness of the efforts of the State to expand the capacity of providers to deliver substance use disorder treatment or recovery services during the period of the demonstration project under this subsection.

(V) The expected financial impact of the demonstration project under this subsection on the State.

(VI) A description of all funding sources available to the State to provide substance use disorder treatment or recovery services in the State.

(VII) A preliminary plan for how the State will sustain any increase in the capacity of providers to deliver substance use disorder treatment or recovery services resulting from the demonstration project under this subsection after the termination of such demonstration project.

(VIII) A description of how the State will coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1315 of this title for the delivery of substance use services under the State plan, as applicable.

(ii) Consultation

In completing an application under clause (i), a State shall consult with relevant stakeholders, including Medicaid managed care plans, health care providers, and Medicaid beneficiary advocates, and include in such application a description of such consultation.

(5) Payment

(A) In general

For each quarter occurring during the period for which the demonstration project is conducted (after the first 18 months of such period), the Secretary shall pay under this subsection, subject to subparagraph (C), to each State selected under paragraph (4) an amount equal to 80 percent of so much of the qualified sums expended during such quarter.

(B) Qualified sums defined

For purposes of subparagraph (A), the term ''qualified sums'' means, with respect to a State and a quarter, the amount equal to the amount (if any) by which the sums expended by the State during such quarter attributable to substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan) exceeds 1/4 of such sums expended by the State during fiscal year 2018 attributable to substance use disorder treatment or recovery services.

(C) Non-duplication of payment

In the case that payment is made under subparagraph (A) with respect to expenditures for substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a

waiver of such plan), payment may not also be made under subsection (a) with respect to expenditures for the same services so furnished.

(6) Reports

(A) State reports

A State receiving payments under paragraph (5) shall, for the period of the demonstration project under this subsection, submit to the Secretary a quarterly report, with respect to expenditures for substance use disorder treatment or recovery services for which payment is made to the State under this subsection, on the following:

(i) The specific activities with respect to which payment under this subsection was provided.

(ii) The number of providers that delivered substance use disorder treatment or recovery services in the State under the demonstration project compared to the estimated number of providers that would have otherwise delivered such services in the absence of such demonstration project.

(iii) The number of individuals enrolled under the State plan (or a waiver of such plan) who received substance use disorder treatment or recovery services under the demonstration project compared to the estimated number of such individuals who would have otherwise received such services in the absence of such demonstration project.

(iv) Other matters as determined by the Secretary.

(B) CMS reports

(i) Initial report

Not later than October 1, 2020, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an initial report on—

(I) the States awarded planning grants under paragraph (3);

(II) the criteria used in such selection; and

(III) the activities carried out by such States under such planning grants.

(ii) Interim report

Not later than October 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an interim report—

(I) on activities carried out under the demonstration project under this subsection;

(II) on the extent to which States selected under paragraph (4) have achieved the stated goals submitted in their applications under subparagraph (C) of such paragraph;

(III) with a description of the strengths and limitations of such demonstration project; and

(IV) with a plan for the sustainability of such project.

(iii) Final report

Not later than October 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress a final report—

(I) providing updates on the matters reported in the interim report under clause (ii);

(II) including a description of any changes made with respect to the demonstration project under this subsection after the submission of such interim report; and

(III) evaluating such demonstration project.

(C) AHRQ report

Not later than 3 years after October 24, 2018, the Director of the Agency for Healthcare Research and Quality, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a summary on the experiences of States awarded planning grants under paragraph (3) and States selected under paragraph (4).

(7) Data sharing and best practices

During the period of the demonstration project under this subsection, the Secretary shall, in collaboration with States selected under paragraph (4), facilitate data sharing and the development of best practices between such States and States that were not so selected.

(8) CMS funding

There is appropriated, out of any funds in the Treasury not otherwise appropriated, $5,000,000 to the Centers for Medicare & Medicaid Services for purposes of implementing this subsection. Such amount shall remain available until expended.

(bb) Supplemental payment reporting requirements

(1) Collection and availability of supplemental payment data

(A) In general

Not later than October 1, 2021, the Secretary shall establish a system for each State to submit reports, as determined appropriate by the Secretary, on supplemental payments data, as a requirement for a State plan or State plan amendment that would provide for a supplemental payment.

(B) Requirements

Each report submitted by a State in accordance with the requirement established under subparagraph (A) shall include the following:

(i) An explanation of how supplemental payments made under the State plan or a State plan amendment will result in payments that are consistent with section 1396a(a)(30)(A) of this title, including standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment.

(ii) The criteria used to determine which providers are eligible to receive the supplemental payment.

(iii) A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including—

(I) data on the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from 1 or more fiscal years, data on the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment;

(II) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data to be used as the basis for calculations regarding the amount or distribution of the supplemental payment; and

(III) the timing of the supplemental payment made to each eligible provider.

(iv) An assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits.

(v) If not already submitted, an upper payment limit demonstration under section 447.272 of title 42, Code of Federal Regulations (as such section is in effect as of December 27, 2020).

(C) Public availability

The Secretary shall make all reports and related data submitted under this paragraph publicly available on the website of the Centers for Medicare & Medicaid Services on a timely basis.

(2) Supplemental payment defined

(A) In general

Subject to subparagraph (B), in this subsection, the term ''supplemental payment'' means a payment to a provider that is in addition to any base payment made to the provider under the State plan under this subchapter or under demonstration authority.

(B) DSH payments excluded

Such term does not include a disproportionate share hospital payment made under section 1396r–4 of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1903, as added Pub. L. 89–97, title I, § 121(a), July 30, 1965, 79 Stat. 349; amended Pub. L. 90–248, title II, §§ 220(a), 222(c), (d), 225(a), 229(c), 241(f)(5), Jan. 2, 1968, 81 Stat. 898, 901, 902, 904, 917; Pub. L. 90–364, title III, § 303(a)(1), June 28, 1968, 82 Stat. 274; Pub. L. 91–56, § 2(a), Aug. 9, 1969, 83 Stat. 99; Pub. L. 92–603, title II, §§ 207(a), 221(c)(6), 224(c), 225, 226(e), 229(c), 230, 233(c), 235(a), 237(a)(1), 249B, 278(b)(1), (5), (7), (16), 290, 295, 299E(a), Oct. 30, 1972, 86 Stat. 1379, 1389, 1395, 1396, 1404, 1410, 1411, 1414, 1415, 1428, 1453, 1454, 1457, 1459, 1462; Pub. L. 93–66, title II, § 234(a), July 9, 1973, 87 Stat. 160; Pub. L. 93–233, §§ 13(a)(11), (12), 18(r)–(v), (x)(5), (6), (y)(1), Dec. 31, 1973, 87 Stat. 963, 971–973; Pub. L. 94–182, title I, §§ 110(a), 111(b), Dec. 31, 1975, 89 Stat. 1054; Pub. L. 94–460, title II, § 202(a), Oct. 8, 1976, 90 Stat. 1957; Pub. L. 94–552, § 1, Oct. 18, 1976, 90 Stat. 2540; Pub. L. 95–83, title I, § 105(a)(1), (2), Aug. 1, 1977, 91 Stat. 384; Pub. L. 95–142, §§ 3(c)(2), 8(c), 10(a), 11(a), 17(a)–(c), 20(a), Oct. 25, 1977, 91 Stat. 1179, 1195, 1196, 1201, 1205; Pub. L. 95–559, § 14(c), Nov. 1, 1978, 92 Stat. 2141; Pub. L. 95–626, title I, § 102(b)(3), Nov. 10, 1978, 92 Stat. 3551; Pub. L. 96–79, title I, § 128, Oct. 4, 1979, 93 Stat. 629; Pub. L. 96–398, title IX, § 901, Oct. 7, 1980, 94 Stat. 1609; Pub. L. 96–499, title IX, §§ 905(b), (c), 961(a), 963, 964, Dec. 5, 1980, 94 Stat. 2618, 2650, 2651; Pub. L. 97–35, title XXI, §§ 2101(a)(2), 2103(b)(1), 2106(b)(3), 2113(n), 2161, 2163, 2164(a), 2174(b), 2178(a), 2183(a), Aug. 13, 1981, 95 Stat. 786, 788, 792, 795, 803–806, 809, 813, 816; Pub. L. 97–248, title I, §§ 133(a), 137(a)(1), (2), (b)(11)–(16), (27), (g), 146(b), Sept. 3, 1982, 96 Stat. 373, 376, 378, 379, 381, 394; Pub. L. 97–448, title III, § 309(b)(16), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–369, div. B, title III, §§ 2303(g)(2), 2363(a)(2), (4), (b), 2364, 2373(b)(11)–(14), July 18, 1984, 98 Stat. 1066, 1106, 1107, 1111, 1112; Pub. L. 98–617, § 3(a)(6), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–272, title IX, §§ 9503(b), (f), 9507(a), 9512(a), 9517(a), (c)(1), 9518(a), Apr. 7, 1986, 100 Stat. 206, 207, 210, 212, 215, 216; Pub. L. 99–509, title IX, §§ 9401(e)(2), 9403(g)(2), 9406(a), 9407(c), 9431(b)(2), 9434(a)(1), (2), (b), Oct. 21, 1986, 100 Stat. 2052, 2055, 2057, 2060, 2066, 2068, 2069; Pub. L. 99–514, title XVIII, § 1895(c)(2), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 99–603, title I, § 121(b)(2), Nov. 6, 1986, 100 Stat. 3390; Pub. L. 100–93, § 8(g), (h)(1), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§ 4112(b), 4113(a)(1), (b)(3), (d)(1), 4118(d)(1), (e)(11), (h)(1), (p)(5), 4211(d)(1), (g), (i), 4212(c)(1), (2), (d)(1), (e)(2), 4213(b)(2), Dec. 22, 1987, 101 Stat. 1330–149, 1330–150, 1330–152, 1330–155, 1330–159, 1330–204, 1330–205, 1330–207, 1330–212, 1330–213, 1330–219, as amended Pub. L. 100–360, title IV, § 411(a)(3)(A), (B)(iii), (k)(6)(B)(x), (7)(A), (D), (10)(D), (G)(ii), July 1, 1988, 102 Stat. 768, 794, 796; Pub. L. 100–360, title II, § 202(h)(2), title III, §§ 301(f), 302(c)(3), (e)(4), title IV, § 411(k)(12)(A), (13)(A), July 1, 1988, 102 Stat. 718, 750, 752, 753, 797, 798; Pub. L. 100–485, title VI, § 608(d)(26)(K)(ii), (f)(4), Oct. 13, 1988, 102 Stat. 2422, 2424; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6401(b), 6411(d)(2), 6901(b)(5)(A), Dec. 19, 1989, 103 Stat. 2259, 2271, 2299; Pub. L. 101–508, title IV, §§ 4401(a)(1), (b)(1), 4402(b), (d)(3), 4601(a)(3)(A), 4701(b)(2), 4704(b)(1), (2), 4711(c)(2), 4723(a), 4731(a), (b)(2), 4732(a), (b)(2), (c), (d), 4751(b)(1), 4752(a)(2), (b)(1), (e), 4801(a)(8), (e)(16)(A), Nov. 5, 1990, 104 Stat. 1388–143, 1388–159, 1388–163, 1388–164, 1388–166, 1388–170, 1388–172, 1388–187, 1388–194 to 1388–196, 1388–205 to 1388–207, 1388–212, 1388–218; Pub. L. 102–119, § 26(i)(1), Oct. 7, 1991, 105 Stat. 607; Pub. L. 102–234, §§ 2(a), (b)(2), 3(b)(2)(B), 4(a), Dec. 12, 1991, 105 Stat. 1793, 1799, 1803, 1804; Pub. L. 103–66, title XIII, §§ 13602(b),

13604(a), 13622(a)(2), 13624(a), 13631(c), (h)(1), Aug. 10, 1993, 107 Stat. 619, 621, 632, 636, 643, 645; Pub. L. 104–193, title I, §114(d)(2), Aug. 22, 1996, 110 Stat. 2180; Pub. L. 104–248, §1(b)(1), Oct. 9, 1996, 110 Stat. 3148; Pub. L. 105–12, §9(b)(1), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§4701(b)(1), (2)(A)(v)–(viii), (B), (C), (c), (d)(2), 4702(b)(1), 4703(a), (b)(1), 4705(b), 4706, 4707(b), 4708(a), (d), 4712(b)(2), (c)(2), 4722(a), (b), 4724(a), (b)(1), 4742(a), 4753(a), 4802(b)(2), 4912(b)(2), Aug. 5, 1997, 111 Stat. 492, 493, 495, 500, 501, 505, 506, 509, 514–516, 523, 525, 549, 573; Pub. L. 105–100, title I, §162(4), Nov. 19, 1997, 111 Stat. 2189; Pub. L. 106–31, title III, §3031(a), (b), May 21, 1999, 113 Stat. 103, 104; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§604(a)(2)(B), (b)(2), 608(e)–(k), (aa)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, 1501A–397, 1501A–398; Pub. L. 106–170, title II, §201(a)(4), (b), title IV, §407(a)–(c), Dec. 17, 1999, 113 Stat. 1893, 1913; Pub. L. 106–354, §2(b)(2)(B), Oct. 24, 2000, 114 Stat. 1383; Pub. L. 106–554, §1(a)(6) [title VII, §§702(c)(1), 710(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, 2763A–578; Pub. L. 108–357, title VII, §712(b), Oct. 22, 2004, 118 Stat. 1559; Pub. L. 108–446, title III, §305(j)(1), Dec. 3, 2004, 118 Stat. 2806; Pub. L. 109–91, title I, §104(b), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109–171, title VI, §§6002(b), 6033(a), 6036(a), 6043(b), 6051(a), 6062(c)(1), 6081, Feb. 8, 2006, 120 Stat. 59, 74, 80, 88, 92, 98, 111; Pub. L. 109–432, div. B, title IV, §§403, 405(c)(1)(A), Dec. 20, 2006, 120 Stat. 2994, 2998; Pub. L. 110–28, title VII, §7002(b)(1), May 25, 2007, 121 Stat. 187; Pub. L. 110–252, title VII, §7001(d)(3), June 30, 2008, 122 Stat. 2394; Pub. L. 110–379, §3(a), Oct. 8, 2008, 122 Stat. 4075; Pub. L. 111–3, title II, §§201(b)(2)(A), 211(a)(1)(B), (3), (b)(1)–(3)(A), (4), 214(a), title IV, §401(b), Feb. 4, 2009, 123 Stat. 39, 52–54, 56, 82; Pub. L. 111–5, div. B, title IV, §4201(a), Feb. 17, 2009, 123 Stat. 489; Pub. L. 111–148, title II, §§2001(a)(2)(B), (5)(D), (e)(2)(B), 2004(c)(1), 2102(a)(8), 2202(b), 2303(a)(4)(B), (b)(2)(B), 2402(d)(2)(A), 2501(c)(1), title VI, §§6402(c), (h)(2), 6504(a), (b)(1), 6506(a)(1), 6507, Mar. 23, 2010, 124 Stat. 272, 275, 279, 283, 288, 291, 294, 296, 303, 308, 757, 760, 776–778; Pub. L. 111–157, §5(a)(2), Apr. 15, 2010, 124 Stat. 1117; Pub. L. 111–309, title II, §205(e), Dec. 15, 2010, 124 Stat. 3290; Pub. L. 114–113, div. O, title V, §503(a)(1), Dec. 18, 2015, 129 Stat. 3020; Pub. L. 114–255, div. A, title V, §§5002, 5005(a)(4), 5008(a), div. B, title XII, §12006(a), div. C, title XVII, §17004(b)(1)(A), Dec. 13, 2016, 130 Stat. 1188, 1192, 1197, 1275, 1332; Pub. L. 115–222, §1(a), July 30, 2018, 132 Stat. 1560; Pub. L. 115–271, title I, §§1003, 1013, 1016(a), title IV, §4001, Oct. 24, 2018, 132 Stat. 3903, 3920, 3922, 3958; Pub. L. 116–16, §§6(a)(2)(A), 8(a), Apr. 18, 2019, 133 Stat. 861, 864; Pub. L. 116–260, div. CC, title II, §§202, 207, 209(a)(3), Dec. 27, 2020, 134 Stat. 2977, 2984, 2986; Pub. L. 117–215, title I, §103(b)(5), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117–328, div. FF, title I, §1262(b)(8), Dec. 29, 2022, 136 Stat. 5682; Pub. L. 118–42, div. G, title I, §211, Mar. 9, 2024, 138 Stat. 414.)

Editorial Notes

References in Text

Subsection (w)(3)(A), referred to in subsec. (b)(5), was in the original ''section 1902(w)(3)(A)'', and was translated as reading ''section 1903(w)(3)(A)'', meaning section 1903(w)(3)(A) of the Social Security Act, to reflect the probable intent of Congress, because section 1902(w)(3), which is classified to section 1396a(w)(3) of this title, does not contain a subpar. (A), and subsec. (w)(3)(A) of this section relates to health care related taxes.

The Individuals with Disabilities Education Act, referred to in subsec. (c), is title VI of Pub. L. 91–230, Apr. 13, 1970, 84 Stat. 175. Parts B and C of the Act are classified generally to subchapters II (§1411 et seq.) and III (§1431 et seq.), respectively, of chapter 33 of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Internal Revenue Code of 1986, referred to in subsecs. (d)(3)(B)(i) and (w)(3)(F), is classified generally to Title 26, Internal Revenue Code.

Section 300e–9(d) of this title, referred to in subsecs. (g)(1) and (m)(1)(A), (4)(A), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (i)(16), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

Sections 254b and 254c of this title, referred to in subsec. (m)(2)(B)(i)(I), (G), were in the original references to sections 329 and 330 of the Public Health Service Act, act July 1, 1944, which were omitted in the general amendment of subpart I (§254b et seq.) of part D of subchapter II of chapter 6A of this title by Pub. L. 104–299, §2, Oct. 11, 1996, 110 Stat. 3626. Sections 2 and 3(a) of Pub. L. 104–299 enacted new sections 330 and 330A of act July 1, 1944, which are classified, respectively, to sections 254b and 254c of this title.

The Appalachian Regional Development Act of 1965, referred to in subsec. (m)(2)(B)(ii), (G), is Pub. L. 89–4, Mar. 9, 1965, 79 Stat. 5, which was set out in the Appendix to former Title 40, Public Buildings, Property, and Works, and was repealed and reenacted as subtitle IV (§14101 et seq.) of Title 40, Public Buildings, Property, and Works, by Pub. L. 107–217, §§1, 6(b), Aug. 21, 2002, 116 Stat. 1062, 1304.

Section 602 of this title, referred to in subsec. (u)(1)(D)(iv), was repealed and a new section 602 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. (a)(26)(C).

The Deficit Reduction Act of 2005, referred to in subsec. (x)(5), is Pub. L. 109–171, Feb. 8, 2006, 120 Stat. 4. Section 6036 of the Act amended this section and enacted provisions set out as notes under this section. For complete classification of this Act to the Code, see Short Title of 2006 Amendment note set out under section 1305 of this title and Tables.

Amendments

2024—Subsec. (m)(9)(A). Pub. L. 118–42 struck out ''(and before fiscal year 2024)'' after ''fiscal year 2020''.

2022—Subsec. (aa)(2)(C)(ii). Pub. L. 117–328, §1262(b)(8), redesignated cl. (iii) as (ii) and struck out former cl. (ii) which read as follows: ''have in effect a registration or waiver under section 823(h) of title 21 for purposes of dispensing narcotic drugs to individuals for maintenance treatment or detoxification treatment and are in compliance with any regulation promulgated by the Assistant Secretary for Mental Health and Substance Use for purposes of carrying out the requirements of such section 823(h); and''.

Pub. L. 117–215 substituted ''823(h)'' for ''823(g)'' in two places.

Subsec. (aa)(2)(C)(iii). Pub. L. 117–328, §1262(b)(8)(C), redesignated cl. (iii) as (ii).

2020—Subsec. (a)(6). Pub. L. 116–260, §207(b), which directed amendment of concluding provisions by striking out ''(as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan (or waiver of such plan))'', was executed by striking out ''(as found necessary by the Secretary for the

elimination of fraud in the provision and administration of medical assistance provided under the State plan)'' after ''such quarter'', to reflect the probable intent of Congress.

Subsec. (i)(9). Pub. L. 116–260, § 209(a)(3), added par. (9).

Subsec. (q)(4)(A)(ii). Pub. L. 116–260, § 207(a), inserted ''and of patients (who are receiving medical assistance under the State plan under this subchapter (or waiver of such plan)) in a noninstitutional or other setting'' after ''patients residing in board and care facilities''.

Subsec. (bb). Pub. L. 116–260, § 202, added subsec. (bb).

2019—Subsec. (i)(10)(C) to (E). Pub. L. 116–16, § 6(a)(2)(A), added subpar. (E) and realigned margins.

Subsec. (i)(12). Pub. L. 116–16, § 8(a), added par. (12).

2018—Subsec. (*l*)(1). Pub. L. 115–222, § 1(a)(1)(A), substituted ''January 1, 2020'' for ''January 1, 2019'' in introductory provisions.

Subsec. (*l*)(1)(A)(i). Pub. L. 115–222, § 1(a)(1)(B), struck out ''2019 and'' before ''2020''.

Subsec. (*l*)(4)(A)(i). Pub. L. 115–222, § 1(a)(2), substituted ''calendar quarters in 2020'' for ''calendar quarters in 2019''.

Subsec. (m)(7). Pub. L. 115–271, § 1013, added par. (7).

Subsec. (m)(8). Pub. L. 115–271, § 1016(a), added par. (8).

Subsec. (m)(9). Pub. L. 115–271, § 4001, added par. (9).

Subsec. (aa). Pub. L. 115–271, § 1003, added subsec. (aa).

2016—Subsec. (i)(2)(A). Pub. L. 114–255, § 5005(a)(4)(A)(i), substituted semicolon for comma at end.

Subsec. (i)(2)(D). Pub. L. 114–255, § 5005(a)(4)(A)(ii), (iii), added subpar. (D).

Subsec. (i)(2)(E). Pub. L. 114–255, § 17004(b)(1)(A), added subpar. (E).

Subsec. (i)(21). Pub. L. 114–255, § 5008(a), inserted ''section 1396r–8(d)(2)(C) of this title (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and'' after ''drugs described in''.

Subsec. (i)(27). Pub. L. 114–255, § 5002, substituted ''January 1, 2018'' for ''January 1, 2019''.

Subsec. (*l*). Pub. L. 114–255, § 12006(a), added subsec. (*l*).

Subsec. (m)(3). Pub. L. 114–255, § 5005(a)(4)(B), added par. (3).

2015—Subsec. (i)(27). Pub. L. 114–113 added par. (27).

2010—Subsec. (a)(3)(E). Pub. L. 111–148, § 2102(a)(8)(A), amended Pub. L. 111–3, § 211(a)(1)(B). See 2009 Amendment note below.

Subsec. (a)(3)(H). Pub. L. 111–148, § 2102(a)(8)(B), amended Pub. L. 111–3, § 211(a)(1)(B). See 2009 Amendment note below.

Subsec. (d)(2)(C). Pub. L. 111–148, § 6506(a)(1)(A), substituted ''1 year'' for ''60 days'' in first sentence and ''1-year period'' for ''60 days'' in second sentence.

Subsec. (d)(2)(D). Pub. L. 111–148, § 6506(a)(1)(B), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (f)(4). Pub. L. 111–148, § 2402(d)(2)(A), inserted ''1396a(a)(10)(A)(ii)(XXII),'' after ''1396a(a)(10)(A)(ii)(XXI),''.

Pub. L. 111–148, § 2303(a)(4)(B), inserted ''1396a(a)(10)(A)(ii)(XXI),'' after ''1396a(a)(10)(A)(ii)(XX),''.

Pub. L. 111–148, § 2004(c)(1), inserted ''1396a(a)(10)(A)(i)(IX),'' after ''1396a(a)(10)(A)(i)(VIII),''.

Pub. L. 111–148, § 2001(e)(2)(B), inserted ''1396a(a)(10)(A)(ii)(XX),'' after ''1396a(a)(10)(A)(ii)(XIX),''.

Pub. L. 111–148, § 2001(a)(5)(D), inserted ''1396a(a)(10)(A)(i)(VIII),'' after ''1396a(a)(10)(A)(i)(VII),''.

Subsec. (i)(2)(C). Pub. L. 111–148, § 6402(h)(2), added subpar. (C).

Subsec. (i)(25). Pub. L. 111–148, § 6402(c), added par. (25).

Subsec. (i)(26). Pub. L. 111–148, § 2001(a)(2)(B), added par. (26).

Subsec. (m)(2)(A)(xi). Pub. L. 111–148, § 6504(b)(1), inserted ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

Subsec. (m)(2)(A)(xiii). Pub. L. 111–148, § 2501(c)(1), added cl. (xiii).

Subsec. (r)(1)(B)(iv). Pub. L. 111–148, § 6507(1), added cl. (iv).

Subsec. (r)(1)(F). Pub. L. 111–148, § 6504(a), inserted ''and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine'' after ''necessary''.

Subsec. (r)(4). Pub. L. 111–148, § 6507(2), added par. (4).

Subsec. (t)(3)(D). Pub. L. 111–157 substituted ''inpatient or emergency room setting'' for ''setting (whether inpatient or outpatient)''.

Subsec. (t)(3)(E). Pub. L. 111–309, § 205(e)(1), substituted ''reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government)'' for ''reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government)''.

Subsec. (t)(6)(B). Pub. L. 111–309, § 205(e)(2), inserted ''and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost'' before period at end.

Subsec. (u)(1)(D)(v). Pub. L. 111–148, § 2303(b)(2)(B), inserted ''or for medical assistance provided to an individual described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period under such section,'' after ''section 1396r–1b of this title during a presumptive eligibility period under such section,''.

Pub. L. 111–148, § 2202(b), substituted ''section, for medical'' for ''section, or for medical'' and inserted before period at end '', or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1396a(a)(47)(B) of this title to be a qualified entity for such purpose''.

2009—Subsec. (a)(2)(E). Pub. L. 111–3, § 201(b)(2)(A), added subpar. (E).

Subsec. (a)(3)(A)(iii). Pub. L. 111–3, § 401(b), added cl. (iii).

Subsec. (a)(3)(D). Pub. L. 111–5, § 4201(a)(1)(A), struck out ''and'' at end.

Subsec. (a)(3)(E)(ii). Pub. L. 111–5, § 4201(a)(1)(B), substituted ''and'' for ''plus'' at end.

Pub. L. 111–3, § 211(a)(1)(B)(i), which directed substitution of ''and'' for ''plus'' at end and could not be executed, was struck out by Pub. L. 111–148, § 2102(a)(8)(A).

Subsec. (a)(3)(F). Pub. L. 111–5, § 4201(a)(1)(C), added subpar. (F).

Subsec. (a)(3)(H). Pub. L. 111–3, § 211(a)(1)(B), as amended by Pub. L. 111–148, § 2102(a)(8)(B), added subpar. (H).

Subsec. (i)(22). Pub. L. 111–3, § 211(a)(3)(A), substituted ''section 1396a(a)(46)(B) of this title'' for ''subsection (x)''.

Subsec. (t). Pub. L. 111–5, § 4201(a)(2), added subsec. (t).

Subsec. (v)(1). Pub. L. 111–3, § 214(a)(1), substituted ''paragraphs (2) and (4)'' for ''paragraph (2)''.

Subsec. (v)(4). Pub. L. 111–3, § 214(a)(2), added par. (4).

Subsec. (x)(1). Pub. L. 111–3, § 211(a)(3)(B), substituted ''section 1396a(a)(46)(B)(i) of this title'' for ''subsection (i)(22)''.

Subsec. (x)(2)(B), (C). Pub. L. 111–3, § 211(b)(4), realigned margins.

Subsec. (x)(2)(D), (E). Pub. L. 111–3, § 211(b)(3)(A)(i), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (x)(3)(B)(v), (vi). Pub. L. 111–3, § 211(b)(1), added cl. (v) and redesignated former cl. (v) as (vi).

Subsec. (x)(4), (5). Pub. L. 111–3, §211(b)(2), (3)(A)(ii), added pars. (4) and (5).

2008—Subsec. (i)(24). Pub. L. 110–252 added par. (24).

Subsec. (r)(1). Pub. L. 110–379, §3(a)(1), inserted '', in addition to meeting the requirements of paragraph (3),'' after ''a State must'' in introductory provisions.

Subsec. (r)(3). Pub. L. 110–379, §3(a)(2), added par. (3).

2007—Subsec. (i)(23). Pub. L. 110–28 added par. (23).

2006—Subsec. (f)(4). Pub. L. 109–171, §6062(c)(1), inserted ''1396a(a)(10)(A)(ii)(XIX),'' after ''1396a(a)(10)(A)(ii)(XVIII),'' in introductory provisions.

Subsec. (i)(10)(C). Pub. L. 109–171, §6002(b), added subpar. (C).

Subsec. (i)(10)(D). Pub. L. 109–171, §6033(a), added subpar. (D).

Subsec. (i)(22). Pub. L. 109–171, §6036(a)(1), added par. (22).

Subsec. (w)(4)(C). Pub. L. 109–432, §403, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (w)(7)(A)(viii). Pub. L. 109–171, §6051(a), amended cl. (viii) generally. Prior to amendment, cl. (viii) read as follows: ''Services of a medicaid managed care organization with a contract under subsection (m) of this section.''

Subsec. (x). Pub. L. 109–171, §6036(a)(2), added subsec. (x).

Subsec. (x)(1). Pub. L. 109–432, §405(c)(1)(A)(i), substituted ''(i)(22)'' for ''(i)(23)''.

Subsec. (x)(2). Pub. L. 109–432, §405(c)(1)(A)(ii)(I), substituted ''individual declaring to be a citizen or national of the United States'' for ''alien'' in introductory provisions.

Subsec. (x)(2)(B). Pub. L. 109–432, §405(c)(1)(A)(ii)(II), added subpar. (B) and struck out former subpar. (B) which read as follows: ''on the basis of receiving supplemental security income benefits under subchapter XVI; or''.

Subsec. (x)(2)(C). Pub. L. 109–432, §405(c)(1)(A)(ii)(V), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 109–432, §405(c)(1)(A)(ii)(III), struck out ''other'' before ''basis'' and substituted ''has'' for ''had''.

Subsec. (x)(2)(D). Pub. L. 109–432, §405(c)(1)(A)(ii)(IV), redesignated subpar. (C) as (D).

Subsec. (x)(3)(C)(iii). Pub. L. 109–432, §405(c)(1)(A)(iii), substituted ''I–197'' for ''I–97''.

Subsec. (y). Pub. L. 109–171, §6043(b), added subsec. (y).

Subsec. (z). Pub. L. 109–171, §6081, added subsec. (z).

2005—Subsec. (i)(21). Pub. L. 109–91 added par. (21).

2004—Subsec. (a)(3)(D). Pub. L. 108–357, §712(b)(1), substituted ''and'' for ''plus''.

Subsec. (a)(3)(E). Pub. L. 108–357, §712(b)(2), added subpar. (E).

Subsec. (c). Pub. L. 108–446 substituted ''part C'' for ''part H''.

2000—Subsec. (f)(4). Pub. L. 106–554, §1(a)(6) [title VII, §710(a)], inserted ''1396a(a)(10)(A)(ii)(XVII), 1396a(a)(10)(A)(ii)(XVIII),'' after ''1396a(a)(10)(A)(ii)(XVI),''.

Subsec. (m)(2)(A)(ix). Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)], repealed Pub. L. 105–33, §4712(c)(2). See 1997 Amendment note below.

Subsec. (u)(1)(D)(v). Pub. L. 106–354 substituted '', for items'' for ''or for items'' and inserted before period at end '', or for medical assistance provided to an individual described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period under such section''.

1999—Subsec. (a)(3)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(2)(B)], struck out ''or quality review'' after ''medical and utilization review''.

Subsec. (b)(4). Pub. L. 106–113, §1000(a)(6) [title VI, §608(e)], inserted ''of'' after ''for the use'' in introductory provisions.

Subsec. (d)(3). Pub. L. 106–31, §3031(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (d)(3)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(f)], realigned margins.

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title VI, §608(g)], struck out second period at end.

Subsec. (f)(4). Pub. L. 106–170, §201(b), inserted ''1396a(a)(10)(A)(ii)(XV), 1396a(a)(10)(A)(ii)(XVI),'' before ''1396d(p)(1)'' in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(2)], substituted ''1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV), or 1396d(p)(1) of this title'' for ''1396d(p)(1), or 1396d(u) of this title'' in introductory provisions.

Subsec. (i)(14). Pub. L. 106–113, §1000(a)(6) [title VI, §608(h)], inserted ''or'' after semicolon.

Subsec. (i)(19). Pub. L. 106–31, §3031(b), added par. (19).

Subsec. (i)(20). Pub. L. 106–170, §201(a)(4), added par. (20).

Subsec. (m)(2)(A)(vi). Pub. L. 106–113, §1000(a)(6) [title VI, §608(i)(1)], struck out semicolon after ''section 1396u–2(a)(4) of this title''.

Subsec. (m)(2)(A)(xi), (xii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(i)(2)], redesignated cl. (xi), relating to section 1396u–2, as (xii).

Subsec. (m)(6)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(2)(A)], inserted ''and'' at end.

Subsec. (m)(6)(B)(iii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(2)(B)], substituted a period for ''; and'' at end.

Subsec. (m)(6)(B)(iv). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(2)(C)], struck out cl. (iv) which read as follows: ''that the State agency will contract, for purposes of meeting the requirement under section 1396a(a)(30)(C) of this title, with an organization or entity that under section 1320c–3 of this title reviews services provided by an eligible organization pursuant to a contract under section 1395mm of this title for the purpose of determining whether the quality of services meets professionally recognized standards of health care.''

Subsec. (*o*). Pub. L. 106–113, §1000(a)(6) [title VI, §608(j)], struck out second closing parenthesis after ''section 1167(1) of title 29''.

Subsec. (q)(3). Pub. L. 106–170, §407(a), inserted ''(A)'' after ''in connection with'' and added subpar. (B).

Subsec. (q)(4). Pub. L. 106–170, §407(c), amended par. (4) generally. Prior to amendment, par. (4) read as follows: ''The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this subchapter, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.''

Subsec. (q)(5). Pub. L. 106–170, §407(b), inserted ''or under any Federal health care program (as so defined)'' before ''to health care facilities'' and inserted at end ''All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection.''

Subsec. (w)(1)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(k)(1)], substituted ''purposes'' for ''puroses''.

Subsec. (w)(3)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(k)(2)], inserted a comma after ''(D)'' in introductory provisions.

Subsec. (w)(7)(A)(viii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(k)(3)], realigned margins.

1997—Subsec. (a)(3)(C). Pub. L. 105–33, §4705(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4). Pub. L. 105–33, §4707(b), added par. (4).

Subsec. (b)(5). Pub. L. 105–33, §4722(b), added par. (5).

Subsec. (f)(4). Pub. L. 105–100 substituted ''1396d(p)(1), or 1396d(u) of this title'' for ''or 1396d(p)(1) of this title'' in introductory provisions.

Subsec. (f)(4)(C). Pub. L. 105–33, §4802(b)(2), inserted ''or who is a PACE program eligible individual enrolled in a PACE program under section 1396u–4 of this title,'' after ''section 1396a(a)(10)(A) of this title,''.

Subsec. (i). Pub. L. 105–33, §4708(d), inserted at end of closing provisions ''Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed

care entity (as defined in section 1396u–2(a)(1)(B) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.''

Subsec. (i)(2). Pub. L. 105–33, § 4724(a)(1), substituted ''; or'' for the period at end.

Subsec. (i)(10)(B), (11). Pub. L. 105–33, § 4724(a)(2), inserted ''or'' at end.

Subsec. (i)(12). Pub. L. 105–33, § 4742(a), struck out par. (12) which related to restrictions on payments, on or after Jan. 1, 1992, for physicians' services to children under 21 years of age and to pregnant women.

Subsec. (i)(13). Pub. L. 105–33, § 4724(a)(2), inserted ''or'' at end.

Subsec. (i)(16). Pub. L. 105–12 added par. (16).

Subsec. (i)(17). Pub. L. 105–33, § 4724(a)(1), (3), added par. (17).

Subsec. (i)(18). Pub. L. 105–33, § 4724(b)(1), added par. (18).

Subsec. (k). Pub. L. 105–33, § 4701(b)(2)(A)(v), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (m)(1)(A). Pub. L. 105–33, § 4701(b)(1), in introductory provisions, substituted ''The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1395mm of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1396a(w) of this title and—'' for ''The term 'health maintenance organization' means a public or private organization, organized under the laws of any State, which meets the requirement of section 1396a(w) of this title is a qualified health maintenance organization (as defined in section 300e–9(d) of this title) or which meets the requirement of section 1396a(a) of this title and—'' and inserted as closing provisions ''An organization that is a qualified health maintenance organization (as defined in section 300e–9(d) of this title) is deemed to meet the requirements of clauses (i) and (ii).''

Subsec. (m)(1)(A)(ii). Pub. L. 105–33, § 4706(1), inserted '', meets the requirements of subparagraph (C)(i) (if applicable),'' after ''provision is satisfactory to the State''.

Subsec. (m)(1)(B). Pub. L. 105–33, § 4701(b)(2)(A)(vi), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (m)(1)(C). Pub. L. 105–33, § 4706(2), added subpar. (C).

Subsec. (m)(2)(A)(i). Pub. L. 105–33, § 4701(b)(2)(A)(vii), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (m)(2)(A)(ii). Pub. L. 105–33, § 4703(a), struck out cl. (ii) which read as follows: ''less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter;''.

Subsec. (m)(2)(A)(iii). Pub. L. 105–33, § 4708(a), substituted ''$1,000,000 for 1998 and, for a subsequent year, the amount established udner this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year'' for ''$100,000''.

Subsec. (m)(2)(A)(vi). Pub. L. 105–33, § 4701(d)(2)(A), struck out ''except as provided under subparagraph (F),'' after ''such contract (I)'', substituted ''in accordance with section 1396u–2(a)(4) of this title;'' for ''without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination'', and inserted ''in accordance with such section'' after ''provides for notification''.

Subsec. (m)(2)(A)(ix). Pub. L. 105–33, § 4712(c)(2), which directed the repeal of subsec. (m)(2)(A)(ix), was repealed by Pub. L. 106–554, § 1(a)(6) [title VII, § 702(c)(1)]. See 2000 Amendment note above and Effective Date of 1997 Amendment note below.

Pub. L. 105–33, § 4712(b)(2), amended cl. (ix) generally. Prior to amendment, cl. (ix) read as follows: ''such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1396a(a)(13)(E) of this title, and (II) at the election of such center payments made by the entity to such a center for services described in 1396d(a)(2)(C) of this title are made at the rates of payment specified in section 1396a(a)(13)(E) of this title;''.

Subsec. (m)(2)(A)(xi). Pub. L. 105–33, § 4701(c), added cl. (xi) relating to section 1396u–2.

Subsec. (m)(2)(C) to (E). Pub. L. 105–33, § 4703(b)(1)(A), struck out subpars. (C) to (E) which read as follows:

''(C) Subparagraph (A)(ii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

''(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.

''(E) In the case of a health maintenance organization that—

''(i) is a nonprofit organization with at least 25,000 members,

''(ii) is and has been a qualified health maintenance organization (as defined in section 300e–9(d) of this title) for a period of at least four years,

''(iii) provides basic health services through members of the staff of the organization,

''(iv) is located in an area designated as medically underserved under section 300e–1(7) of this title, and

''(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1315 of this title,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.''

Subsec. (m)(2)(F). Pub. L. 105–33, § 4701(d)(2)(B), struck out subpar. (F) which read as follows: ''In the case of—

''(i) a contract with an entity described in subparagraph (E) or (G), with a qualified health maintenance organization (as defined in section 300e–9(d) of this title) which meets the requirement of subparagraph (A)(ii), or or with an eligible organization with a contract under section 1395mm of this title which meets the requirement of subparagraph (A)(ii), or

''(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of subchapter XVIII of this chapter or eligible for benefits under this subchapter, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.''

Subsec. (m)(2)(G). Pub. L. 105–33, §4703(b)(1)(B), substituted ''clause (i)'' for ''clauses (i) and (ii)''.

Subsec. (m)(2)(H). Pub. L. 105–33, §4702(b)(1)(B), in concluding provisions, inserted before period at end ''or with the manager described in such clause if the manager continues to have a contract described in section 1396d(t)(3) of this title with the State''.

Pub. L. 105–33, §4701(b)(2)(B), struck out ''health maintenance'' before ''organization described'' in concluding provisions.

Subsec. (m)(2)(H)(i). Pub. L. 105–33, §4702(b)(1)(A), inserted ''or with a primary care case manager with a contract described in section 1396d(t)(3) of this title'' before comma at end.

Pub. L. 105–33, §4701(b)(2)(A)(vii), substituted ''medicaid managed care organization'' for ''health maintenance organization''.

Subsec. (m)(4)(A). Pub. L. 105–33, §4701(b)(2)(A)(viii), substituted ''Each medicaid managed care organization'' for ''Each health maintenance organization''.

Subsec. (r)(1). Pub. L. 105–33, §4753(a)(1), added par. (1) and struck out former par. (1) which read as follows:

''(1)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) of this section without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) of this section and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

''(B) The deadline for operation of such systems for a State is September 30, 1985.

''(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

''(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

''(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).''

Subsec. (r)(2). Pub. L. 105–33, §4753(a)(1), (2)(B), (D), inserted introductory provisions, redesignated par. (5)(A)(i) to (iii) as par. (2)(A) to (C), and struck out former par. (2) which read as follows:

''(2)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) of this section without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

''(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

''(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

''(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

''(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

''(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) of this section on or before October 7, 1980, shall be deemed to be initially approved for purposes of this subsection.''

Subsec. (r)(3), (4). Pub. L. 105–33, §4753(a)(1), struck out pars. (3) and (4) which related to Federal matching funds and Secretary's periodic review of approved retrieval systems.

Subsec. (r)(5). Pub. L. 105–33, §4753(a)(2), struck out introductory provisions relating to requirements for Secretary's initial approval of mechanized claims processing and information retrieval systems and struck out ''under paragraph (6)'' before period at end of subpar. (A)(iii), redesignated subpar. (A)(i) to (iii) as par. (2)(A) to (C), and struck out subpar. (B) which related to requirements for Secretary's reapproval of mechanized claims processing and information retrieval systems.

Subsec. (r)(6) to (8). Pub. L. 105–33, §4753(a)(3), struck out pars. (6) to (8) which related to Secretary's development of performance standards for approval of State mechanized processing claims and information retrieval systems, waiver of certain requirements for initial operation, and applicability of per centum reductions in certain situations.

Subsec. (u)(1)(D)(v). Pub. L. 105–33, §4912(b)(2), inserted before period at end ''or for items and services described in subsection (a) of section 1396r–1a of this title provided to a child during a presumptive eligibility period under such section''.

Subsec. (w)(3)(B). Pub. L. 105–33, §4722(a)(1), substituted ''(E), and (F)'' for ''and (E)'' in introductory provisions.

Subsec. (w)(3)(F). Pub. L. 105–33, §4722(a)(2), added subpar. (F).

Subsec. (w)(7)(A)(viii). Pub. L. 105–33, §4701(b)(2)(C), amended cl. (viii) generally. Prior to amendment, cl. (viii) read as follows: ''Services of health maintenance organizations (and other organizations with contracts under subsection (m) of this section).''

1996—Subsec. (i)(9). Pub. L. 104–193 struck out par. (9) which read as follows: ''with respect to any amount of medical assistance for pregnant women and children described in section 1396a(a)(10)(A)(ii)(IX) of this title, if the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are less than the payment levels in effect under such plan on July 1, 1987;''.

Subsec. (i)(12)(A)(i). Pub. L. 104–248, §1(b)(1)(A), inserted ''or is certified in family practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association'' before comma at end.

Subsec. (i)(12)(A)(vi). Pub. L. 104–248, §1(b)(1)(C)(i), (iii), (iv), added cl. (vi) and redesignated former cl. (vi) as (vii).

Pub. L. 104–248, §1(b)(1)(C)(ii), inserted ''(or certified by the State in accordance with policies of the Secretary)'' after ''Secretary''.

Subsec. (i)(12)(A)(vii). Pub. L. 104–248, §1(b)(1)(C)(iii), redesignated cl. (vi) as (vii).

Subsec. (i)(12)(B)(i). Pub. L. 104–248, §1(b)(1)(B), inserted ''or is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association'' before comma at end.

Subsec. (i)(12)(B)(vi). Pub. L. 104–248, §1(b)(1)(C)(i), (iii), (iv), added cl. (vi) and redesignated former cl. (vi) as (vii).

Pub. L. 104–248, §1(b)(1)(C)(ii), inserted ''(or certified by the State in accordance with policies of the Secretary)'' after ''Secretary''.

Subsec. (i)(12)(B)(vii). Pub. L. 104–248, §1(b)(1)(C)(iii), redesignated cl. (vi) as (vii).

1993—Subsec. (i)(10). Pub. L. 103–66, §13631(c)(1), which directed the amendment of par. (10) by striking all that follows ''1396r–8(g) of this title'' and inserting a semicolon, could not be executed because ''1396r–8(g) of this title'' did not appear subsequent to the general amendment of par. (10) by Pub. L. 103–66, §13602(b). See below.

Pub. L. 103–66, §13602(b), amended par. (10) generally. Prior to amendment, par. (10) read as follows: ''with respect to covered outpatient drugs of a manufacturer dispensed in any State unless, (A) except as provided in section 1396r–8(a)(3) of this title, the manufacturer complies with the rebate requirements of section 1396r–8(a) of this title with respect to the drugs so dispensed in all States, and (B) effective January 1, 1993, the State provides for drug use review in accordance with section 1396r–8(g) of this title; or''.

Subsec. (i)(11). Pub. L. 103–66, §13631(c)(2), redesignated par. (12) as (11), transferred such par. to appear after par. (10), and substituted semicolon for period at end. Former par. (11) redesignated (13).

Subsec. (i)(12). Pub. L. 103–66, §13631(c)(3), redesignated par. (14) as (12), transferred such par. to appear after par. (11), as redesignated by Pub. L. 103–66, §13631(c)(2), and substituted semicolon for period at end. Former par. (12) redesignated (11).

Subsec. (i)(13). Pub. L. 103–66, §13631(c)(4), redesignated par. (11) as (13), transferred such par. to appear after par. (12), as redesignated by Pub. L. 103–66, §13631(c)(3), and directed substitution of ''; or'' for period at end.

Subsec. (i)(14). Pub. L. 103–66, §13631(c)(5), added par. (14).

Subsec. (i)(15). Pub. L. 103–66, §13631(h)(1), added par. (15).

Subsec. (*o*). Pub. L. 103–66, §13622(a)(2), substituted ''regulation and including a group health plan (as defined in section 1167(1) of title 29)), a service benefit plan, and a health maintenance organization)'' for ''regulation)''.

Subsec. (s). Pub. L. 103–66, §13624(a), added subsec. (s).

Subsec. (v)(2)(C). Pub. L. 103–66, §13604(a), added subpar. (C).

1991—Subsec. (a)(1). Pub. L. 102–234, §3(b)(2)(B), inserted ''and section 1396r–4(f) of this title'' after ''of this section''.

Subsec. (c). Pub. L. 102–119 substituted ''child with a disability'' for ''handicapped child'', ''Individuals with Disabilities Education Act'' for ''Education of the Handicapped Act'', and ''an infant or toddler with a disability'' for ''a handicapped infant or toddler''.

Subsec. (d)(6). Pub. L. 102–234, §4(a), added par. (6).

Subsec. (i)(10). Pub. L. 102–234, §2(b)(2), struck out par. (10) added by Pub. L. 101–508, §4701(b)(2)(B), which read as follows: ''with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State soley [sic] with respect to hospitals or facilities.''

Subsec. (w). Pub. L. 102–234, §2(a), added subsec. (w).

1990—Subsec. (a)(1). Pub. L. 101–508, §4402(d)(3), struck out before semicolon ''(including expenditures for medicare cost-sharing and including expenditures 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, or part A of subchapter IV, 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 sixty-five years of age or older and disabled individuals entitled to hospital 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)(2)(B). Pub. L. 101–508, §4801(a)(8), substituted ''October 1, 1990'' for ''July 1, 1990''.

Subsec. (a)(3)(C), (D). Pub. L. 101–508, §4401(b)(1), substituted ''and'' for ''plus'' at end of subpar. (C) and added subpar. (D).

Subsec. (f)(2). Pub. L. 101–508, §4723(a), inserted ''(A)'' after ''(2)'' and added cl. (B).

Subsec. (f)(4). Pub. L. 101–508, §4601(a)(3)(A), substituted ''1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII)'' for ''1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(VI)''.

Subsec. (i)(8). Pub. L. 101–508, §4711(c)(2), inserted ''(A)'' after ''medical assistance'' and added cl. (B).

Subsec. (i)(10). Pub. L. 101–508, §4701(b)(2), added par. (10) relating to any amount expended for medical assistance for care or services.

Pub. L. 101–508, §4401(a)(1), added par. (10) relating to covered outpatient drugs.

Subsec. (i)(11). Pub. L. 101–508, §4801(e)(16)(A), added par. (11).

Subsec. (i)(12). Pub. L. 101–508, §4752(a)(2), added par. (12).

Subsec. (i)(14). Pub. L. 101–508, §4752(e), added par. (14).

Subsec. (m)(1)(A). Pub. L. 101–508, §4751(b)(1), inserted ''meets the requirement of section 1396a(w) of this title'' after ''State, which'' and ''meets the requirement of section 1396a(a) of this title and'' after ''or which''.

Subsec. (m)(2)(A)(i). Pub. L. 101–508, §4732(d)(1), struck out ''(or the State as authorized by paragraph (3))'' after ''the Secretary''.

Subsec. (m)(2)(A)(ix). Pub. L. 101–508, §4704(b)(1), added cl. (ix).

Subsec. (m)(2)(A)(x). Pub. L. 101–508, §4731(a), added cl. (x).

Subsec. (m)(2)(A)(xi). Pub. L. 101–508, §4752(b)(1), added cl. (xi).

Subsec. (m)(2)(B). Pub. L. 101–508, §4704(b)(2), inserted ''except with respect to clause (ix) of subparagraph (A),'' after ''Subparagraph (A)''.

Subsec. (m)(2)(D). Pub. L. 101–508, §4732(a), struck out ''(i) special circumstances warrant such modification or waiver, and (ii)'' after ''the Secretary determines that''.

Subsec. (m)(2)(F)(i). Pub. L. 101–508, §4732(b)(2), substituted ''(G),'' for ''(G) or'' and inserted at end ''or with an eligible organization with a contract under section 1395mm of this title which meets the requirement of subparagraph (A)(ii), or''.

Subsec. (m)(2)(H). Pub. L. 101–508, §4732(c), added subpar. (H).

Subsec. (m)(3). Pub. L. 101–508, §4732(d)(2), struck out par. (3) which read as follows: ''A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this subchapter that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).''

Subsec. (m)(5)(A)(v). Pub. L. 101–508, §4731(b)(2), added cl. (v).

Subsec. (u)(1)(D)(iv). Pub. L. 101–508, §4402(b), which directed amendment of subpar. (C)(iv) by inserting be-

fore period at end ''or with respect to payments made in violation of section 1396e of this title'', was executed to subpar. (D)(iv) to reflect the probable intent of Congress because subpar. (C) does not have a cl. (iv).

1989—Subsec. (a)(2)(B). Pub. L. 101–239, §6901(b)(5)(A), inserted ''(including the costs for nurse aides to complete such competency evaluation programs)'' after ''1396r(e)(1) of this title'' and ''(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)'' after ''50 percent''.

Subsec. (f)(4). Pub. L. 101–239, §6401(b), inserted ''1396a(a)(10)(A)(i)(VI),'' after ''1396a(a)(10)(A) (i)(IV),''.

Subsec. (i)(2). Pub. L. 101–239, §6411(d)(2), inserted '', not including items or services furnished in an emergency room of a hospital'' after ''emergency item or service''.

Subsec. (i)(5). Pub. L. 101–234 repealed Pub. L. 100–360, §202(h)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a)(1). Pub. L. 100–360, §301(f), amended Pub. L. 99–509, §9403(g)(2), see 1986 Amendment note below.

Subsec. (c). Pub. L. 100–360, §411(k)(13)(A), added subsec. (c).

Subsec. (f)(2). Pub. L. 100–360, §411(k)(10)(G)(ii), amended Pub. L. 100–203, §4118(h)(1), see 1987 Amendment note below.

Subsec. (f)(4). Pub. L. 100–360, §302(e)(4), inserted ''1396a(a)(10)(A)(i)(IV),'' before ''1396a(a)(10)(A)(ii)(IX)'' in introductory provisions.

Subsec. (i)(2)(A). Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), added Pub. L. 100–203, §4118(e)(11)(A), see 1987 Amendment note below.

Subsec. (i)(2)(B). Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), added Pub. L. 100–203, §4118(e)(11)(B), see 1987 Amendment note below.

Subsec. (i)(3). Pub. L. 100–360, §411(k)(6)(B)(x), added Pub. L. 100–203, §4112(b), see 1987 Amendment note below.

Subsec. (i)(5). Pub. L. 100–360, §202(h)(2), substituted ''section 1395y(c)(1)'' for ''section 1395y(c)''.

Subsec. (i)(9). Pub. L. 100–360, §302(c)(3), added par. (9).

Subsec. (m)(2)(B)(i)(II). Pub. L. 100–485, §608(f)(4), substituted ''1396a(a)(10)(D) of this title'' for ''1396a(a)(13)(A)(ii) of this title''.

Subsec. (m)(2)(F). Pub. L. 100–360, §411(k)(7)(D), repealed Pub. L. 100–203, §4113(d)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(a)(3)(A), (B)(iii), (k)(7)(A), amended Pub. L. 100–203, §4113(a)(1)(B), see 1987 Amendment note below.

Subsec. (m)(5). Pub. L. 100–360, §411(k)(12)(A), amended par. (5) generally. Prior to amendment, par. (5) read as follows:

''(A) Any entity with a contract under this subsection that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

''(B) The provisions of section 1320a–7a of this title (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.''

1987—Subsec. (a)(1). Pub. L. 100–203, §4211(g)(2), substituted ''and (j)'' for '', (h), and (j)''.

Subsec. (a)(2)(A) to (C). Pub. L. 100–203, §4211(d)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (a)(2)(D). Pub. L. 100–203, §4212(c)(1), added subpar. (D).

Subsec. (a)(3)(C). Pub. L. 100–203, §4113(b)(3), inserted ''or by an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary,'' after ''organization''.

Subsec. (a)(7). Pub. L. 100–203, §4212(e)(2), inserted ''subject to section 1396r(g)(3)(B) of this title,'' after ''(7)''.

Subsec. (f)(2). Pub. L. 100–203, §4118(h)(1), as amended by Pub. L. 100–360, §411(k)(10)(G)(ii), substituted ''(whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof)'' for ''(whether in the form of insurance premiums or otherwise)''.

Subsec. (f)(4). Pub. L. 100–203, §4118(p)(5), inserted '', 1396a(a)(10)(A)(ii)(X), or 1396d(p)(1)'' after ''1396a(a)(10)(A)(ii)(IX)''.

Subsec. (g)(1). Pub. L. 100–203, §4212(d)(1)(A), substituted ''or services in an intermediate care facility for the mentally retarded'' for first reference to ''or intermediate care facility services'', struck out '', skilled nursing facility services for 30 days,'' after first reference to ''60 days'', substituted ''or services in an intermediate care facility for the mentally retarded'' for '', skilled nursing facility services, or intermediate care facility services'', and substituted ''and intermediate care facilities for the mentally retarded'' for '', skilled nursing facilities, and intermediate care facilities''.

Subsec. (g)(4)(B). Pub. L. 100–203, §4212(d)(1)(B), substituted ''and intermediate care facilities for the mentally retarded'' for '', skilled nursing facilities, and intermediate care facilities''.

Subsec. (g)(6)(B) to (D). Pub. L. 100–203, §4212(d)(1)(C), redesignated subpar. (C) as (B) and substituted ''services in an intermediate care facility for the mentally retarded'' for ''intermediate care facility services'', redesignated subpar. (D) as (C), and struck out former subpar. (B) which read as follows: ''Such recertifications in the case of skilled nursing facility services shall be conducted at least—

''(i) 30 days after the date of the initial certification,

''(ii) 60 days after the date of the initial certification,

''(iii) 90 days after the date of the initial certification, and

''(iv) every 60 days thereafter.''

Subsec. (g)(7). Pub. L. 100–203, §4212(d)(1)(D), struck out par. (7) which read as follows: ''It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this subchapter, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.''

Subsec. (h). Pub. L. 100–203, §4211(g)(1), struck out subsec. (h) which related to reduction by Secretary of amount otherwise considered as expenditures under State plan where reasonable cost differential between statewide average cost of skilled nursing facility services and statewide average cost of intermediate care facility services does not exist for any calendar quarter beginning after June 30, 1973.

Subsec. (i). Pub. L. 100–203, §4118(d)(1)(B), inserted sentence at end that nothing in par. (1) be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose.

Subsec. (i)(1). Pub. L. 100–203, §4118(d)(1)(A), substituted ''; or'' for period at end.

Subsec. (i)(2). Pub. L. 100–93, §8(g), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under subchapter XVIII of this chapter with respect to services furnished by such provider or person during such period of time solely by reason of a

determination by the Secretary under section 1395y(d)(1) of this title or under clause (D), (E), or (F) of section 1395cc(b)(2) of this title, or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1395cc(b)(2) or under section 1396a(a)(38) of this title; or''.

Subsec. (i)(2)(A). Pub. L. 100–203, § 4118(e)(11)(A), as added by Pub. L. 100–360, § 411(k)(10)(D), as amended by Pub. L. 100–485, § 608(d)(26)(K)(ii), substituted ''under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title'' for ''in the State plan under this subchapter pursuant to section 1320a–7 of this title or section 1320a–7a of this title''.

Subsec. (i)(2)(B). Pub. L. 100–203, § 4118(e)(11)(B), as added by Pub. L. 100–360, § 411(k)(10)(D), as amended by Pub. L. 100–485, § 608(d)(26)(K)(ii), substituted ''from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title'' for ''pursuant to section 1320a–7 of this title or section 1320a–7a of this title from participation in the program under this subchapter''.

Subsec. (i)(3). Pub. L. 100–203, § 4112(b), as added by Pub. L. 100–360, § 411(k)(6)(B)(x), inserted ''(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)'' before ''to the extent''.

Subsec. (i)(4). Pub. L. 100–203, § 4211(i), struck out ''or skilled nursing facility'' after ''hospital'' in three places.

Subsec. (i)(8). Pub. L. 100–203, § 4213(b)(2), added par. (8).

Subsec. (m)(2)(F). Pub. L. 100–203, § 4113(d)(1), which directed the substitution of ''subparagraphs (E) or (G)'' for ''subparagraph (G)'', was repealed by Pub. L. 100–360, § 411(k)(7)(D).

Pub. L. 100–203, § 4113(a)(1)(B), as amended by Pub. L. 100–360, § 411(a)(3)(A), (B)(iii), (k)(7)(A), substituted ''(F) In the case of—'' and cls. (i) and (ii) for ''(F) In the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 300e–9(d) of this title) which meets the requirement of subparagraph (A)(ii),''.

Subsec. (m)(6). Pub. L. 100–203, § 4113(a)(1)(A), added par. (6).

Subsec. (n). Pub. L. 100–93, § 8(h)(1), struck out subsec. (n) which related to State agency action upon disclosure or failure to disclose required information by institution, organization, etc.

Subsec. (r). Pub. L. 100–203, § 4212(c)(2), substituted ''paragraphs (2)(A)'' for ''paragraphs (2)'' in pars. (1)(A), (C) and (2)(A), (C).

1986—Subsec. (a)(1). Pub. L. 99–509, § 9403(g)(2), as amended by Pub. L. 100–360, § 301(f), inserted ''including expenditures for medicare cost-sharing and'' before ''including expenditures''.

Subsec. (a)(3)(C). Pub. L. 99–509, § 9431(b)(2), inserted ''or quality review'' after ''medical and utilization review''.

Subsec. (a)(4). Pub. L. 99–603 added par. (4).

Subsec. (d)(2). Pub. L. 99–272, § 9512(a), designated first sentence as subpar. (A), designated second sentence as subpar. (B), properly indented and aligned below subpar. (A), and added subpars. (C) and (D).

Subsec. (f)(4). Pub. L. 99–509, § 9401(e)(2), inserted ''for any individual described in section 1396a(a)(10)(A)(ii)(IX) of this title or'' after ''as medical assistance''.

Subsec. (i)(1). Pub. L. 99–272, § 9507(a), added par. (1).

Subsec. (m)(2)(A). Pub. L. 99–272, § 9517(a)(1), substituted ''subparagraphs (B), (C), and (G)'' for ''subparagraphs (B) and (C)'' in introductory text.

Pub. L. 99–272, § 9517(c)(1), inserted ''(including a health insuring organization)'' after ''any entity'' and ''(directly or through arrangements with providers of services)'' after ''responsible for the provision'' in introductory text.

Subsec. (m)(2)(A)(iii). Pub. L. 99–509, § 9434(a)(2), inserted before the semicolon ''and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $100,000''.

Subsec. (m)(2)(A)(viii). Pub. L. 99–509, § 9434(a)(1)(A), added cl. (viii).

Subsec. (m)(2)(F). Pub. L. 99–514, § 1895(c)(2), substituted ''In the case'' for ''in the case''.

Pub. L. 99–272, § 9517(a)(2), struck out designation ''(i)'' at beginning of subpar. (F), substituted ''in the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 300e–9(d) of this title) which meets the requirement of subparagraph (A)(ii)'' for ''In the case of a contract with a health maintenance organization described in clause (ii)'', substituted ''such entity or organization'' for ''such organization'', and struck out cl. (ii) which defined a health maintenance organization.

Subsec. (m)(2)(G). Pub. L. 99–272, § 9517(a)(3), added subpar. (G).

Subsec. (m)(4). Pub. L. 99–509, § 9434(a)(1)(B), added par. (4).

Subsec. (m)(5). Pub. L. 99–509, § 9434(b), added par. (5).

Subsec. (r)(1)(B). Pub. L. 99–272, § 9518(a), substituted ''September 30, 1985'' for ''the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before October 7, 1980''.

Subsec. (r)(4)(A). Pub. L. 99–272, § 9503(b)(2), substituted ''once every three years'' for ''once each fiscal year'' and inserted at end ''Reviews may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews.''

Subsec. (r)(6)(J). Pub. L. 99–272, § 9503(b)(1), amended subpar. (J) generally. Prior to amendment, subsec. (J) read as follows: ''report on or before October 1, 1981, to the Congress on the extent to which States have developed and operated effective mechanized claims processing and information retrieval systems.''

Subsec. (u)(1)(D)(iv). Pub. L. 99–272, § 9503(f), added cl. (iv).

Subsec. (u)(1)(D)(v). Pub. L. 99–509, § 9407(c), added cl. (v).

Subsec. (v). Pub. L. 99–509, § 9406(a), added subsec. (v).

1984—Subsec. (g)(1). Pub. L. 98–369, § 2363(a)(2)(A), (B), in provision preceding subpar. (A), substituted ''inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for'' for ''care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on'', and struck out ''which for purposes of this section means the four calendar quarters ending with June 30,'' before ''the Federal medical assistance percentage'', and struck out ''in the same fiscal year'' before ''shall be decreased by a per centum thereof''.

Pub. L. 98–369, § 2363(a)(2)(C), substituted '', skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams'' for ''(including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—'' and former subpars. (A) through (D) requirement for evidence concerning an effective program of utilization of certain medical services.

Subsec. (g)(4)(B). Pub. L. 98–369, §2373(b)(11), substituted ''paragraphs (26)'' for ''paragraph (26)'' and ''diligence'' for ''deligence''.

Subsec. (g)(6). Pub. L. 98–369, §2363(a)(4), in amending par. (6) generally, substituted provisions relating to recertifications for provisions relating to reports to Congress concerning Secretary's determination and review of showing respecting any decrease of Federal medical assistance percentage of amounts paid for services.

Subsec. (g)(7). Pub. L. 98–369, §2363(b), as amended by Pub. L. 98–617, §3(a)(6), added par. (7).

Subsec. (i)(7). Pub. L. 98–369, §2303(g)(2), added par. (7).

Subsec. (m)(2)(A)(vi). Pub. L. 98–369, §2364(1), inserted ''except as provided under subparagraph (F),'' after ''(I)''.

Subsec. (m)(2)(B)(i)(I). Pub. L. 98–369, §2373(b)(12)(A), (C), struck out ''(II)'' before ''for the period'' and substituted ''period'' for ''peroid''.

Subsec. (m)(2)(B)(i)(II). Pub. L. 98–369, §2373(b)(12)(B), substituted ''of section 1396d(a) of this title'' for ''of such section''.

Subsec. (m)(2)(C). Pub. L. 98–369, §2373(b)(13), realigned margin of subpar. (C).

Subsec. (m)(2)(E), (F). Pub. L. 98–369, §2364(2), added subpars. (E) and (F).

Subsec. (s)(3)(B). Pub. L. 98–369, §2373(b)(14), substituted ''non-Federal'' for ''nonfederal''.

1983—Subsec. (t)(3). Pub. L. 97–448 substituted ''purposes'' for ''purpose'' and ''the lower of the Federal medical assistance percentage for the State in effect for fiscal year 1981, or the Federal medical assistance percentage for the State in effect for fiscal year 1982'' for ''the Federal medical assistance percentage for States in effect for fiscal year 1981, disregarding any change in such percentage after fiscal year 1981''.

1982—Subsec. (a)(3)(C). Pub. L. 97–248, §146(b), substituted ''utilization and quality control peer review organization'' for ''Professional Standards Review Organization''.

Subsec. (f)(3). Pub. L. 97–248, §137(g), struck out ''(without regard to section 608 of this title)'' after ''consisting of one person if such plan''.

Subsec. (g)(1). Pub. L. 97–248, §137(b)(11), inserted ''or which is a qualified health maintenance organization (as defined in section 300e–9(d) of this title)''.

Subsec. (g)(1)(A). Pub. L. 97–248, §137(b)(12), substituted ''provided in an institution for the mentally retarded'' for ''described in section 1396d(d) of this title''.

Subsec. (k). Pub. L. 97–248, §137(b)(13), substituted ''subsection (m) of this section'' for ''section 1395mm of this title''.

Subsec. (m)(2)(A). Pub. L. 97–248, §137(b)(14), substituted ''or'' for ''and'' before ''(II)'' in cl. (iv), and substituted ''unforeseen'' for ''unforseen'' in cl. (vii)(II).

Subsec. (s). Pub. L. 97–248, §137(a)(2), amended directory language of Pub. L. 97–35, §2161(c)(1), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (s)(1)(A). Pub. L. 97–248, §137(b)(15)(A), (B), in provisions following cl. (iii), substituted ''fiscal year 1982'' for ''fiscal year 1981'', and ''subsections (a)(6) and (t) of this section, without regard to payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service,'' for ''subsection (t) of this section''.

Subsec. (s)(1)(C). Pub. L. 97–248, §137(b)(15)(C), inserted ''a program in operation under'', before ''a plan approved''.

Subsec. (s)(3)(D). Pub. L. 97–248, §137(b)(15)(D), substituted ''must determine that'' for ''determines that'', ''most recent year (which shall consist of a 12-month period determined by the Secretary for this purpose)'' for ''most recent calendar year'', and ''2- or 3-year period'' for ''2 or 3 calendar year period'', and struck out ''calendar'' wherever appearing.

Subsec. (s)(4)(B). Pub. L. 97–248, §137(b)(15)(E), inserted ''and paragraph (3)(D)''.

Subsec. (s)(5)(A)(i). Pub. L. 97–248, §137(b)(15)(F), inserted ''(including amounts saved, to the extent such amounts can be documented to the satisfaction of the Secretary, by reason of the suspension or termination of a provider or other person for fraud or abuse, but only during the period of such suspension or termination or, if shorter, the 1-year period beginning on the date of such termination or suspension)'' after ''recovered or diverted''.

Subsec. (s)(5)(B). Pub. L. 97–248, §137(b)(27), inserted ''or quarters'' after ''carried forward to the following quarter''.

Subsec. (t). Pub. L. 97–248, §137(a)(1), (2), amended directory language of Pub. L. 97–35, §2161(b), (c)(2), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (t)(1)(A). Pub. L. 97–248, §137(b)(16)(A), substituted ''payments under subsection (a)(6) of this section, interest paid under subsection (d)(5) of this section, and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service'' for ''interest paid under subsection (d)(5) of this section''.

Subsec. (t)(1)(B). Pub. L. 97–248, §137(b)(16)(B), (D), substituted ''Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics'' for ''consumer price index for all urban consumers (published by the Bureau of Labor Statistics)'' and ''for the 12-month period ending on September 30, 1983'' for ''between September 1982 and September 1983''.

Subsec. (t)(1)(C). Pub. L. 97–248, §137(b)(16)(C), (D), substituted ''Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics'' for ''consumer price index for all urban consumers (published by the Bureau of Labor Statistics)'' and ''for the 24-month period ending on September 30, 1984'' for ''between September 1982 and September 1984''.

Subsec. (t)(2)(A). Pub. L. 97–248, §137(b)(16)(A), substituted ''payments under subsection (a)(6) of this section, interest paid under subsection (d)(5) of this section, and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service'' for ''interest paid under subsection (d)(5) of this section''.

Subsec. (t)(3). Pub. L. 97–248, §137(b)(16)(E), substituted ''for fiscal years 1982, 1983, and 1984'' for ''for fiscal year 1984'' wherever appearing, ''years 1983, 1984, and 1985, respectively'' for ''year 1985'', ''in effect for fiscal year 1981'' for ''in effect for fiscal year 1983'', and ''after fiscal year 1981'' for ''between fiscal year 1983 and fiscal year 1984''.

Subsec. (u). Pub. L. 97–248, §133(a), added subsec. (u).

1981—Subsec. (a)(3)(B). Pub. L. 97–35, §2113(n), substituted ''and'' for ''plus'' at the end of subpar. (B) and added subpar. (C).

Subsec. (d)(5). Pub. L. 97–35, §2163, substituted ''determination at a rate'' for ''determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at a rate''.

Subsec. (e). Pub. L. 97–35, §2101(a)(2), added subsec. (e).

Subsec. (g)(1)(A). Pub. L. 97–35, §2183(a), inserted ''and the physician, or a physician assistant or nurse practitioner under the supervision of a physician'' and ''or, in the case of services that are intermediate care facility services described in section 1396d(d) of this title, every year'' in parenthetical text.

Subsec. (i)(1). Pub. L. 97–35, §2174(b), struck out par. (1) which provided that payments shall not be made with respect to any amount paid for items or services furnished under the plan after Dec. 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under fourth and fifth sentences of section 1395u(b)(3) of this title.

Subsec. (i)(5). Pub. L. 97–35, §2103(b)(1), added par. (5).

Subsec. (i)(6). Pub. L. 97–35, § 2164(a), added par. (6).

Subsec. (m)(1)(A). Pub. L. 97–35, § 2178(a)(1), redefined ''Health Maintenance Organization'' substantially, and substituted reference to public and private organizations making services to individuals eligible for benefits under this subchapter and which makes adequate provision against the risk of insolvency for reference to a legal entity which provides health services to individuals enrolled in such organization and providing services and benefits to individuals eligible for benefits under specified provisions of this subchapter.

Subsec. (m)(2)(A). Pub. L. 97–35, § 2178(a)(2), in cl. (ii), substituted ''75 percent of the membership of the entity which is enrolled on a prepaid basis'' for ''one-half of the membership of the entity'', and added cls. (iii) to (vii).

Subsec. (m)(2)(D). Pub. L. 97–35, § 2178(a)(3), added subpar. (D).

Subsec. (n). Pub. L. 97–35, § 2106(b)(3), struck out ''of this section'' after ''section 1395cc of this title'' thereby perfecting the amendment made by Pub. L. 96–499, § 905(c)(2).

Subsec. (s). Pub. L. 97–35, § 2161(c)(1), as amended by Pub. L. 97–248, § 137(a)(2), repealed subsec. (s) which provided for reduction in medicaid payments to States, limitations on reductions, States included, and percentage reductions reduced under certain circumstances. See Effective Date of 1981 Amendment note below.

Pub. L. 97–35, § 2161(a), added subsec. (s).

Subsec. (t). Pub. L. 97–35, § 2161(c)(2), as amended by Pub. L. 97–248, § 137(a)(2), repealed subsec. (t) which provided for offset for meeting Federal medicaid expenditure targets, and computation for meeting expenditure targets. See Effective Date of 1981 Amendment note below.

Pub. L. 97–35, § 2161(b), as amended by Pub. L. 97–248, § 137(a)(1), added subsec. (t).

1980—Subsec. (a)(1). Pub. L. 96–499, § 905(b), inserted reference to subsection (j) of this section.

Subsec. (a)(6). Pub. L. 96–499, § 963, substituted ''such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and (B) 75 per centum of the sums expended during each succeeding calendar quarter'' for ''each quarter beginning on or after October 1, 1977, and ending before October 1, 1980''.

Subsec. (d)(5). Pub. L. 96–499, § 961(a), added par. (5).

Subsec. (g)(3)(B). Pub. L. 96–499, § 964, substituted ''January 1, 1978'' for ''October 1, 1977'' and ''any calendar quarter ending on or before December 31, 1978'' for ''the calendar quarter ending on December 31, 1977''.

Subsec. (j). Pub. L. 96–499, § 905(c)(1), substituted provisions relating to the adjustment of amounts determined under subsec. (a)(1) of this section in accordance with section 1396m of this title for provisions relating to orders for suspension of payment.

Subsec. (n). Pub. L. 96–499, § 905(c)(2), struck out ''or is subject to a suspension of payment order issued under subsection (j)'' after ''section 1395cc of this title''.

Subsec. (r). Pub. L. 96–398 added subsec. (r).

1979—Subsec. (m)(2)(C). Pub. L. 96–79 substituted ''the date the entity qualifies as a health maintenance organization (as determined by the Secretary)'' for ''the date the entity enters into a contract with the State under this subchapter for the provision of health services on a prepaid risk basis''.

1978—Subsec. (m)(1)(B). Pub. L. 95–559 struck out ''shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions'' after ''subparagraph (A),''.

Subsec. (m)(2)(B)(i)(I). Pub. L. 95–626 substituted ''section 254b(d)(1)(A)'' for ''section 247d(d)(1)(A)''.

1977—Subsec. (a)(3)(B). Pub. L. 95–142, § 10(a), inserted provisions relating to notice to individuals in a sample group and provisions exempting notice respecting confidential services from notice requirements.

Subsec. (a)(6), (7). Pub. L. 95–142, § 17(a), added par. (6) and redesignated former par. (6) as (7).

Subsec. (b)(3). Pub. L. 95–142, § 17(b), added par. (3).

Subsec. (g). Pub. L. 95–142, § 20(a), in par. (1) substituted ''Subject to paragraph (3), with respect to'' for ''With respect to'' and ''by a per centum thereof (determined under paragraph (5))'' for ''by 33⅓ per centum thereof'', in par. (2) inserted ''timely'' before ''sample onsite surveys'', and added pars. (3) to (6).

Subsec. (i)(2). Pub. L. 95–142, § 3(c)(2), inserted provisions relating to noncompliance under sections 1395cc(b)(2) and 1396a(a)(38) of this title.

Subsec. (m)(2)(A). Pub. L. 95–83, § 105(a)(1), in revising text, incorporated former cl. (i) (I) and (II) provisions in introductory text relating to responsibility for providing inpatient hospital services and other described services, substituting ''capitation basis'' for ''capitation risk basis'' and inserting ''unless''; redesignated as cl. (i) former cl. (ii), substituting ''has determined that the entity is a health maintenance organization'' for ''has not determined to be a health maintenance organization''; and redesignated as cl. (ii) former cl. (iii), substituting ''less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter'' for ''more than one-half of the membership of which consists of individuals who are insured under parts A and B of subchapter XVIII of this chapter or recipients of benefits under this subchapter.''

Subsec. (m)(2)(C). Pub. L. 95–83, § 105(a)(2), substituted reference to subpar. ''(A)(ii)'' for ''(A)(iii)'' wherever appearing.

Subsec. (n). Pub. L. 95–142, § 8(c), added subsec. (n).

Subsecs. (*o*), (p). Pub. L. 95–142, § 11(a), added subsecs. (*o*) and (p).

Subsec. (q). Pub. L. 95–142, § 17(c), added subsec. (q).

1976—Subsec. (*l*). Pub. L. 94–552 repealed subsec. (*l*) which provided for reduction of amount of payments to States found not to be in compliance with section 1396a(g) of this title.

Subsec. (m). Pub. L. 94–460 added subsec. (m).

1975—Subsec. (g)(1)(C). Pub. L. 94–182, § 110(a), inserted provisions specifying the method by which the size and composition of the sample of admissions subject to review is to be established.

Subsec. (*l*). Pub. L. 94–182, § 111(b), added subsec. (*l*).

1973—Subsec. (a). Pub. L. 93–233, § 18(x)(5), struck out reference to section 1317 of this title in introductory parenthetical phrase.

Subsec. (a)(1). Pub. L. 93–233, §§ 13(a)(11), 18(r)(1), substituted ''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 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'' for ''individuals who are recipients of money payments under a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter'' and inserted ''and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter,'' after ''individuals sixty-five years of age or older''.

Subsec. (a)(4). Pub. L. 93–233, § 18(s), substituted ''sums expended with respect to costs incurred'' for ''sums expended''.

Subsec. (a)(5). Pub. L. 93–233, § 18(t), struck out ''(as found necessary by the Secretary for the proper and efficient administration of the plan)'' after ''such quarter''.

Subsec. (b). Pub. L. 93–233, §§ 18(r)(2), (u), (x)(6), inserted in par. (2) after ''individuals sixty-five years of age or older'' text reading ''and disabled individuals entitled to hospital insurance benefits under subchapter XVIII'' and end text reading '', other than amounts ex-

pended under provisions of the plan of such State required by section 1396a(a)(34) of this title,'' and redesignated pars. (2) and (3) as (1) and (2), respectively.

Subsec. (c). Pub. L. 93–233, §18(y)(1)(A), struck out subsec. (c) which provided for Federal medical assistance percentage and Federal share of State medical expenses during fiscal year ending June 30, 1965.

Subsec. (d)(1). Pub. L. 93–233, §18(y)(1)(B), struck out reference to subsec. (c) of this section.

Subsec. (f)(4). Pub. L. 93–233, §13(a)(12), in subpar. (A), made payment limitations inapplicable to individual with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; in subpar. (B), made payment limitations inapplicable to individual with respect to whom such benefits are not being paid, and in cls. (i) and (ii) inserted ''to have such benefits paid with respect to him'', and added subpar. (C).

Subsec. (g)(1)(C). Pub. L. 93–233, §18(v), substituted ''directly responsible for the care of the patient or financially interested in any such institution or, except in the case of hospitals, employed by the institution'' for ''directly responsible for the care of the patient and who are not employed by or financially interested in any such institution''.

Subsec. (j). Pub. L. 93–66 struck out provisions respecting skilled nursing facility services and intermediate care facility services.

1972—Subsec. (a)(1). Pub. L. 92–603, §207(a)(2), inserted reference to subsecs. (g) and (h) and of this section.

Subsec. (a)(3). Pub. L. 92–603, §235(a), added par. (3). Former par. (3) redesignated (4).

Subsec. (a)(4). Pub. L. 92–603, §249B, temporarily added par. (4) which provided for payments to States of 100 per centum of sums expended for costs incurred during a quarter attributable to compensation or training of personnel responsible for inspecting public or private institutions providing long-term care to recipients of medical assistance to determine compliance with health or safety standards. Former par. 4 redesignated (5). See Effective Date of 1972 Amendment note below.

Pub. L. 92–603, §235(a), redesignated former par. (3) as (4).

Subsec. (a)(5). Pub. L. 92–603, §299E(a), added par. (5). Former par. (5) redesignated (6).

Pub. L. 92–603, §249B, redesignated former par. (4) as (5).

Subsec. (a)(6). Pub. L. 92–603, §299E, redesignated former par. (5) as (6).

Subsec. (b)(1). Pub. L. 92–603, §295, struck out par. (1) which related to amount of quarterly expenditures exceeding average of total expenditures for each quarter of fiscal year ending June 30, 1965.

Subsec. (b)(3). Pub. L. 92–603, §221(c)(6), added par. (3).

Subsec. (e). Pub. L. 92–603, §230, repealed subsec. (e) which related to furnishing for comprehensive care and services by July 1, 1977.

Subsec. (g). Pub. L. 92–603, §§207(a)(1), 278(b)(1), added subsec. (g) and substituted ''skilled nursing facility'' for ''skilled nursing home'' and ''skilled nursing facilities'' for ''skilled nursing homes'' wherever appearing.

Subsec. (h). Pub. L. 92–603, §§207(a)(1), 278(b)(1)(5), added subsec. (h) and substituted ''skilled nursing facility'' for ''skilled nursing home'' wherever appearing.

Subsec. (i). Pub. L. 92–603, §§224(c), 229(c), 233(c), 237(a)(1), 278(b)(7), added subsec. (i) and substituted ''skilled nursing facility'' for ''skilled nursing home'' wherever appearing.

Subsec. (j). Pub. L. 92–603, §290, added subsec. (j) relating to orders for suspension of payment.

Pub. L. 92–603, §§225, 278(b)(16), added subsec. (j) relating to skilled nursing facilities services, and substituted ''skilled nursing facility'' for ''skilled nursing home'' wherever appearing.

Subsec. (k). Pub. L. 92–603, §226(e), added subsec. (k).

1969—Subsec. (e). Pub. L. 91–56 extended from July 1, 1975, to July 1, 1977, the date by which comprehensive care and services for eligible individuals must be made available for a State to be eligible for payments.

1968—Subsec. (a)(1). Pub. L. 90–248, §222(d), substituted ''and, except in the case of individuals sixty-five years of age or older who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums'' for ''and other insurance premiums''.

Pub. L. 90–248, §241(f)(5), struck out ''IV,'' after ''I,'' and inserted ''or part A of subchapter IV of this chapter,'' after ''XVI of this chapter,''.

Subsec. (a)(2). Pub. L. 90–248, §225(a), substituted ''of the State agency or any other public agency'' for ''of the State agency (or of the local agency administering the State plan in the political subdivision)''.

Subsec. (b). Pub. L. 90–248, §222(c), designated existing provisions as par. (1) and added par. (2).

Subsec. (b)(2). Pub. L. 90–364 substituted ''1969'' for ''1967''.

Subsec. (d)(2). Pub. L. 90–248, §229(c), provided for treatment of expenditures for which payments were made to the State under subsec. (a) as an overpayment to the extent that the State or local agency administering the plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

Subsec. (f). Pub. L. 90–248, §220(a), added subsec. (f).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 209(a)(3) of Pub. L. 116–260 effective Dec. 27, 2020, and applicable to transportation furnished on or after such date, see section 209(a)(4) of Pub. L. 116–260, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Amendment by section 6(a)(2)(A) of Pub. L. 116–16 effective on Apr. 18, 2019, and applicable to covered outpatient drugs supplied by manufacturers under agreements under section 1396r–8 of this title on or after that date, see section 6(e) of Pub. L. 116–16, set out as a note under section 1320a–7 of this title.

Pub. L. 116–16, §8(b), Apr. 18, 2019, 133 Stat. 864, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after January 1, 2020.''

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1016(c), Oct. 24, 2018, 132 Stat. 3923, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Oct. 24, 2018].''

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, §5008(b), Dec. 13, 2016, 130 Stat. 1197, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning on or after the date of the enactment of this Act [Dec. 13, 2016].''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–309, title II, §205(e), Dec. 15, 2010, 124 Stat. 3290, provided that the amendment made by section 205(e) is effective as if included in the enactment of section 4201(a)(2) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5).

Amendment by Pub. L. 111–157 effective as if included in the enactment of the HITECH Act (Pub. L. 111–5, div. A, title XIII, div. B, title IV), see section 5(b) of Pub. L. 111–157, set out as a note under section 1395w–4 of this title.

Amendment by section 2004(c)(1) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(d) 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 II, § 2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by section 2102(a)(8) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

Amendment by section 2202(b) of Pub. L. 111–148 effective Jan. 1, 2014, and applicable to services furnished on or after that date, see section 2202(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)(B), (b)(2)(B) 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)(A) 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 VI, § 6504(b)(2), Mar. 23, 2010, 124 Stat. 777, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to contract years beginning on or after January 1, 2010.''

Pub. L. 111–148, title VI, § 6506(a)(2), Mar. 23, 2010, 124 Stat. 777, provided that: ''The amendments made by this subsection [amending this section] take effect on the date of enactment of this Act [Mar. 23, 2010] and apply to overpayments discovered on or after that date.''

Amendment by sections 6504(a) and 6507 of Pub. L. 111–148 effective Jan. 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle F (§§ 6501–6508) of title VI of Pub. L. 111–148 have been promulgated by that date, see section 6508 of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 201(b)(2)(A), 214(a), and 401(b) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Amendment by section 211 of Pub. L. 111–3 effective Jan. 1, 2010, except that amendment by section 211(b)(1)–(3)(A) of Pub. L. 111–3 effective as if included in the enactment of section 6036 of Pub. L. 109–171 and amendment by section 211(b)(4) of Pub. L. 111–3 effective as if included in the enactment of section 405 of Pub. L. 109–432, with restoration of eligibility and special transition rule for Indians, see section 211(d) of Pub. L. 111–3, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–379, § 3(b), Oct. 8, 2008, 122 Stat. 4075, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) [amending this section] take effect on October 1, 2009.

''(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements 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 these additional requirements 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 [Oct. 8, 2008]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.''

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–28, title VII, § 7002(b)(2), May 25, 2007, 121 Stat. 188, as amended by Pub. L. 110–90, § 5, Sept. 29, 2007, 121 Stat. 985, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to prescriptions executed after March 31, 2008.''

[Pub. L. 110–90, § 5, Sept. 29, 2007, 121 Stat. 985, provided in part that the amendment by section 5 of Pub. L. 110–90 to section 7002(b)(2) of Pub. L. 110–28, set out above, is effective as if included in the enactment of section 7002(b) of Pub. L. 110–28.]

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, § 405(c)(1)(A), Dec. 20, 2006, 120 Stat. 2998, provided that the amendment made by section 405(c)(1)(A) is effective as if included in the amendment made by section 6036(a)(2) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].

Pub. L. 109–171, title VI, § 6033(b), Feb. 8, 2006, 120 Stat. 74, provided that: ''The amendments made by subsection (a) [amending this section] take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act [Feb. 8, 2006].''

Pub. L. 109–171, title VI, § 6036(b), Feb. 8, 2006, 120 Stat. 81, as amended by Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(v)(I), Dec. 20, 2006, 120 Stat. 3000, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(x) of the Social Security Act [42 U.S.C. 1396b(x)], as added by such amendments, was not previously met.''

Pub. L. 109–171, title VI, § 6043(c), Feb. 8, 2006, 120 Stat. 88, provided that: ''The amendments made by this section [amending this section and section 1396*o*–1 of this title] shall apply to non-emergency services furnished on or after January 1, 2007.''

Pub. L. 109–171, title VI, § 6051(b), Feb. 8, 2006, 120 Stat. 92, provided that:

''(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall be effective as of the date of the enactment of this Act [Feb. 8, 2006].

''(2) DELAY IN EFFECTIVE DATE.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

''(B) SPECIFIED STATES.—For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a Medicaid managed care organization with a contract under section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)] as of December 8, 2005.''

Amendment by section 6062(c)(1) of 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 2005 AMENDMENT

Pub. L. 109–91, title I, § 104(d), Oct. 20, 2005, 119 Stat. 2093, provided that: ''The amendments made by this section [amending this section and sections 1396r–8 and 1396u–5 of this title] shall apply to drugs dispensed on or after January 1, 2006.''

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–357, title VII, §712(d), Oct. 22, 2004, 118 Stat. 1561, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1396d of this title] take effect on the date of enactment of this Act [Oct. 22, 2004] and apply to medical assistance and services provided under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after that date.''

EFFECTIVE DATE OF 2000 AMENDMENTS

Amendment by section 702(c)(1) of Pub. L. 106–554 effective Jan. 1, 2001, and applicable to services furnished on or after such date, see section 1(a)(6) [title VII, §702(e)] of Pub. L. 106–554, set out as a note under section 1396a of this title.

Pub. L. 106–554, §1(a)(6) [title VII, §710(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, provided that:

''(1) The amendment made by subsection (a)(1) [amending this section] shall be effective as if included in the enactment of section 121 of the Foster Care Independence Act of 1999 (Public Law 106–169 [amending sections 1396a and 1396d of this title and enacting provisions set out as notes under section 1396a of this title]).

''(2) The amendment made by subsection (a)(2) [amending this section] shall be effective as if included in the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106–354).''

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 AMENDMENT

Amendment by section 201(a)(4), (b) of 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.

Pub. L. 106–170, title IV, §407(d), Dec. 17, 1999, 113 Stat. 1914, provided that: ''The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Dec. 17, 1999].''

Amendment by section 1000(a)(6) [title VI, §604(a)(2)(B), (b)(2)] of Pub. L. 106–113 applicable as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1396u–2(c)(2) of this title, see section 1000(a)(6) [title VI, §604(c)(2)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

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)(2)] 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(e)–(k)] 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.

Pub. L. 106–31, title III, §3031(c), May 21, 1999, 113 Stat. 104, provided that: ''This section [amending this section] and the amendments made by this section shall apply to amounts paid to a State prior to, on, or after the date of the enactment of this Act [May 21, 1999].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, 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.

Pub. L. 105–33, title IV, §4710, Aug. 5, 1997, 111 Stat. 506, provided that:

''(a) GENERAL EFFECTIVE DATE.—Except as otherwise provided in this chapter [chapter 1 (§§4701–4710) of subtitle H of title IV of Pub. L. 105–33, enacting section 1396u–2 of this title, amending this section and sections 1320a–3, 1320a–7b, 1396a, 1396d, 1396*o*, 1396r–6, 1396r–8, 1396u–2, and 1396v of this title, and enacting provisions set out as a note under section 1396u–2 of this title] and section 4759 [enacting provisions set out as a note under section 1396a of this title], the amendments made by this chapter shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to contracts entered into or renewed on or after October 1, 1997.

''(b) SPECIFIC EFFECTIVE DATES.—Subject to subsection (c) and section 4759—

''(1) PCCM OPTION.—The amendments made by section 4702 [amending this section and sections 1396a and 1396d of this title] shall apply to primary care case management services furnished on or after October 1, 1997.

''(2) 75:25 RULE.—The amendments made by section 4703 [amending this section and section 1396r–6 of this title] apply to contracts under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) on and after June 20, 1997.

''(3) QUALITY STANDARDS.—Section 1932(c)(1) of the Social Security Act [42 U.S.C. 1396u–2(c)(1)], as added by section 4705(a), shall take effect on January 1, 1999.

''(4) SOLVENCY STANDARDS.—

''(A) IN GENERAL.—The amendments made by section 4706 [amending this section] shall apply to contracts entered into or renewed on or after October 1, 1998.

''(B) TRANSITION RULE.—In the case of an organization that as of the date of the enactment of this Act [Aug. 5, 1997] has entered into a contract under section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)] with a State for the provision of medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.] under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by section 4706 shall not apply to such organization until 3 years after the date of the enactment of this Act.

''(5) SANCTIONS FOR NONCOMPLIANCE.—Section 1932(e) of the Social Security Act [42 U.S.C. 1396u–2(e)], as added by section 4707(a), shall apply to contracts entered into or renewed on or after April 1, 1998.

''(6) LIMITATION ON FFP FOR ENROLLMENT BROKERS.—The amendment made by section 4707(b) [amending this section] shall apply to amounts expended on or after October 1, 1997.

''(7) 6-MONTH GUARANTEED ELIGIBILITY.—The amendments made by section 4709 [amending section 1396a of this title] shall take effect on October 1, 1997.

''(c) NONAPPLICATION TO WAIVERS.—Nothing in this chapter (or the amendments made by this chapter) shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n).''

Amendment by section 4712(b)(2) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4712(b)(3) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Pub. L. 105–33, title IV, §4712(c), Aug. 5, 1997, 111 Stat. 509, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, which provided that the amendment made by section 4712(c) was effective for services furnished on or after Oct. 1, 2004, was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, effective Jan. 1, 2001, and applicable to services furnished on or after such date.

Pub. L. 105–33, title IV, §4722(d), Aug. 5, 1997, 111 Stat. 515, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to taxes imposed before, on, or after the date of the enactment of this Act [Aug. 5, 1997] and the amendment made by subsection (b) [amending this section] shall apply to taxes imposed on or after such date.''

Pub. L. 105–33, title IV, § 4724(b)(2), Aug. 5, 1997, 111 Stat. 516, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to home health care services furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, § 4742(b), Aug. 5, 1997, 111 Stat. 523, 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 [Aug. 5, 1997].''

Amendment by section 4753(a) of Pub. L. 105–33 effective Jan. 1, 1998, except as otherwise specifically provided, see section 4753(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Amendment by section 4912(b)(2) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4912(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–248, § 1(b)(2), Oct. 9, 1996, 110 Stat. 3149, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to physicians' services furnished on or after January 1, 1992.''

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13602(b) of Pub. L. 103–66 effective as if included in enactment of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, see section 13602(d)(1) of Pub. L. 103–66, set out as a note under section 1396r–8 of this title.

Pub. L. 103–66, title XIII, § 13604(b), Aug. 10, 1993, 107 Stat. 621, provided that:

''(1) Subject to paragraph (2), the amendments made by subsection (a) [amending this section] shall apply as if included in the enactment of OBRA–1986 [Pub. L. 99–509].

''(2) The Secretary of Health and Human Services shall not disallow expenditures made for the care and services described in section 1903(v)(2)(C) of the Social Security Act [42 U.S.C. 1396b(v)(2)(C)], as added by subsection (a), furnished before the date of the enactment of this Act [Aug. 10, 1993].''

Amendment by section 13622(a)(2) of Pub. L. 103–66 applicable to items and services furnished on or after Oct. 1, 1993, see section 13622(d)(3) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Pub. L. 103–66, title XIII, § 13624(b), Aug. 10, 1993, 107 Stat. 636, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to referrals made on or after December 31, 1994.''

Pub. L. 103–66, title XIII, § 13631(h)(2), Aug. 10, 1993, 107 Stat. 645, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to amounts expended for vaccines administered on or after October 1, 1993.''

Amendment by section 13631(c) of Pub. L. 103–66 applicable to payments under State plans approved under this subchapter for calendar quarters beginning on or after Oct. 1, 1994, see section 13631(i) of Pub. L. 103–66, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1991 AMENDMENT

Amendments by section 2(a), (b)(2) of Pub. L. 102–234 effective Jan. 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date, see section 2(c)(1) of Pub. L. 102–234, set out as a note under section 1396a of this title.

Amendment by section 3(b)(2)(B) of Pub. L. 102–234 effective Jan. 1, 1992, see section 3(e)(1) of Pub. L. 102–234, set out as a note under section 1396a of this title.

Pub. L. 102–234, § 4(b), Dec. 12, 1991, 105 Stat. 1804, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to fiscal years ending after the date of the enactment of this Act [Dec. 12, 1991].''

EFFECTIVE DATE OF 1990 AMENDMENTS

Amendment by section 4402(b), (d)(3) 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 4601(a)(3)(A) 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.

Pub. L. 101–508, title IV, § 4701(c), Nov. 5, 1990, 104 Stat. 1388–171, provided that: ''The amendment made by subsection (b) [amending this section and section 1396a of this title] shall take effect on January 1, 1991.''

Amendment by section 4704(b)(1), (2) 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.

Amendment by section 4711(c)(2) of Pub. L. 101–508 applicable to civil money penalties imposed after Nov. 5, 1990, see section 4711(e)(2)(B) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, § 4731(c), Nov. 5, 1990, 104 Stat. 1388–195, provided that: ''The amendments made by subsections (a) and (b)(2) [amending this section] shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by subsection (b)(1) [amending section 1320a–7a of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].''

Amendment by section 4751(b)(1) of Pub. L. 101–508 applicable with respect to services furnished on or after first day of first month beginning more than 1 year after Nov. 5, 1990, see section 4751(c) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, § 4752(b)(2), Nov. 5, 1990, 104 Stat. 1388–206, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning after the date of the establishment of the system described in section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)].''

Pub. L. 101–508, title IV, § 4801(a)(9), Nov. 5, 1990, 104 Stat. 1388–212, provided that: ''Except as provided in paragraph (6), the amendments made by this subsection [amending this section and section 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

Pub. L. 101–508, title IV, § 4801(e)(16)(B), Nov. 5, 1990, 104 Stat. 1388–218, provided that: ''The amendments made by subparagraph (A) [amending this section] shall

apply with respect to actions initiated on or after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6401(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, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out the amendments by section 6401 of Pub. L. 101–239 have been promulgated by such date, see section 6401(c) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6901(b)(5)(A) of Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 6901(b)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 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 AMENDMENT

Amendment by section 608(d)(26)(K)(ii) 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)(4) 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 202(h)(2) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Pub. L. 100–360, title III, §301(f), July 1, 1988, 102 Stat. 750, provided that the amendment made by that section is effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99–509.

Amendment by section 302(c)(3) of Pub. L. 100–360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after that date, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, see section 302(f) 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(a)(3)(A), (B)(iii), (k)(6)(B)(x), (7)(A), (D), (10)(D), (G)(ii) 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.

Pub. L. 100–360, title IV, §411(k)(12)(B), July 1, 1988, 102 Stat. 798, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [July 1, 1988].''

Pub. L. 100–360, title IV, §411(k)(13)(B), July 1, 1988, 102 Stat. 798, 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

Pub. L. 100–203, title IV, §4118(d)(2), Dec. 22, 1987, 101 Stat. 1330–155, provided that: ''The amendments made by paragraph (1) [amending this section] shall be effective as if included in the enactment of section 9507 of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].''

Amendment by section 4118(h)(1) of Pub. L. 100–203 applicable to costs incurred after Dec. 22, 1987, see section 4118(h)(3) of Pub. L. 100–203, as amended, set out as a note under section 1396a of this title.

Amendments by sections 4211(d)(1), (g), (i), 4212(c)(1), (2), (d)(1), (e)(2) 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 1396r 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.

Amendment by section 4212(d)(1) of Pub. L. 100–203 not applicable until such date as of which the State has specified the resident assessment instrument under section 1396r(e)(5) of this title, and the State has begun conducting surveys under section 1396r(g)(2) of this title, see section 4212(d)(4) of Pub. L. 100–203, set out as a note under section 1396a of this title.

Amendment by section 4213(b)(2) of Pub. L. 100–203 applicable to payments under this subchapter for calendar quarters beginning on or after Dec. 22, 1987, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, see section 4214(b)(1) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99–603, set out as a note under section 502 of this title.

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 9401(e)(2) of Pub. L. 99–509 applicable to medical assistance furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether of not final regulations to carry out such amendment have been promulgated by such date, see section 9401(f) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9403(g)(2) 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 9406(a) of Pub. L. 99–509 applicable, except as otherwise provided, to medical assistance furnished to aliens on or after Jan. 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9406(c) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9407(c) of Pub. L. 99–509 applicable to ambulatory prenatal care furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9407(d) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9431(b)(2) 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 9431(c) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Pub. L. 99–509, title IX, §9434(a)(3), Oct. 21, 1986, 100 Stat. 2069, provided that:

''(A) The amendments made by paragraph (1) [amending this section] shall take effect 6 months after the date of the enactment of this Act [Oct. 21, 1986].

''(B) The amendment made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act and shall apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on the date of the enactment of this Act.''

Amendment by section 9503(b), (f) of Pub. L. 99–272 applicable to calendar quarters beginning on or after Apr. 7, 1986, except as otherwise provided, see section 9503(g)(1), (2) of Pub. L. 99–272, set out as a note under section 1396a of this title.

Pub. L. 99–272, title IX, § 9507(b), Apr. 7, 1986, 100 Stat. 210, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to medical assistance furnished on or after January 1, 1987.''

Pub. L. 99–272, title IX, § 9512(b), Apr. 7, 1986, 100 Stat. 213, provided that: ''The amendments made by this section [amending this section] shall apply to overpayments identified for quarters beginning on or after October 1, 1985.''

Pub. L. 99–272, title IX, § 9517(c)(2), (3), Apr. 7, 1986, 100 Stat. 216, as amended by Pub. L. 99–509, title IX, § 9435(e), Oct. 21, 1986, 100 Stat. 2070; Pub. L. 99–514, title XVIII, § 1895(c)(4), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 101–508, title IV, § 4734, Nov. 5, 1990, 104 Stat. 1388–196; Pub. L. 104–240, § 1(a), Oct. 8, 1996, 110 Stat. 3140; Pub. L. 106–554, § 1(a)(6) [title VII, § 704(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–575; Pub. L. 110–275, title II, § 205(a), July 15, 2008, 122 Stat. 2593, provided that:

''(2)(A) Except as provided in subparagraph (B) and in paragraph (3), the amendments made by paragraph (1) [amending this section] shall apply to expenditures incurred for health insuring organizations which first become operational on or after January 1, 1986. For purposes of this paragraph, a health insuring organization is not considered to be operational until the date on which it first enrolls patients.

''(B) In the case of a health insuring organization—

''(i) which first becomes operational on or after January 1, 1986, but

''(ii) for which the Secretary of Health and Human Services has waived, under section 1915(b) of the Social Security Act [42 U.S.C. 1396n(b)] and before such date, certain requirements of section 1902 of such Act [42 U.S.C. 1396a],

clauses (ii) and (vi) of section 1903(m)(2)(A) of such Act [42 U.S.C. 1396b(m)(2)(A)(ii), (vi)] shall not apply during the period for which such waiver is effective.

''(C) In the case of the Hartford Health Network, Inc., clauses (ii) and (vi) of section 1903(m)(2)(A) of the Social Security Act shall not apply during the period for which a waiver by the Secretary of Health and Human Services, under section 1915(b) of such Act, of certain requirements of section 1902 of such Act is in effect (pursuant to a request for a waiver under section 1915(b) of such Act submitted before January 1, 1986).

''(D) Nothing in section 1903(m)(1)(A) of the Social Security Act shall be construed as requiring a health-insuring organization to be organized under the health maintenance organization laws of a State.

''(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County, which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

''(B) A health insuring organization described in this subparagraph is one that—

''(i) is operated directly by a public entity established by a county government in the State of California under a State enabling statute;

''(ii) enrolls all medicaid beneficiaries residing in the county or counties in which it operates;

''(iii) meets the requirements for health maintenance organizations under the Knox-Keene Act (Cal. Health and Safety Code, section 1340 et seq.) and the Waxman-Duffy Act (Cal. Welfare and Institutions Code, section 14450 et seq.);

''(iv) assures a reasonable choice of providers, which includes providers that have historically served medicaid beneficiaries and which does not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary;

''(v) provides for a payment adjustment for a disproportionate share hospital (as defined under State law consistent with section 1923 of the Social Security Act [42 U.S.C. 1396r–4]) in a manner consistent with the requirements of such section; and

''(vi) provides for payment, in the case of childrens' hospital services provided to medicaid beneficiaries who are under 21 years of age, who are children with special health care needs under title V of the Social Security Act [42 U.S.C. 701 et seq.], and who are receiving care coordination services under such title, at rates determined by the California Medical Assistance Commission.

''(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds 16 percent of the number of such beneficiaries in the State of California.

''(D) In this paragraph, the term 'medicaid beneficiary' means an individual who is entitled to medical assistance under the State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than a qualified medicare beneficiary who is only entitled to such assistance because of section 1902(a)(10)(E) of such title [42 U.S.C. 1396a(a)(10)(E)].''

[Pub. L. 110–275, title II, § 205(b), July 15, 2008, 122 Stat. 2594, provided that: ''The amendments made by subsection (a) [amending section 9517(c)(3)(A), (C) of Pub. L. 99–272, set out above] shall take effect on the date of the enactment of this Act [July 15, 2008].'']

[Pub. L. 106–554, § 1(a)(6) [title VII, § 704(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–575, provided that: ''The amendment made by subsection (a) [amending section 9517(c)(3)(C) of Pub. L. 99–272, set out above] takes effect on the date of the enactment of this Act [Dec. 21, 2000].'']

[Pub. L. 104–240, § 1(b), Oct. 8, 1996, 110 Stat. 3140, provided that: ''The amendment made by subsection (a) [amending section 9517(c)(3)(B)(ii) of Pub. L. 99–272, set out above] shall apply to quarters beginning on or after October 1, 1996.'']

Pub. L. 99–272, title IX, § 9518(b), Apr. 7, 1986, 100 Stat. 216, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to payment under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for calendar quarters beginning on or after October 1, 1982.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(2) of Pub. L. 98–369 applicable to payments for calendar quarters beginning on or after Oct. 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(2) and (3) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Pub. L. 98–369, div. B, title III, § 2363(c), July 18, 1984, 98 Stat. 1107, provided that: ''The amendments made by subsection (a) [amending this section and section 1396a

of this title] apply to calendar quarters beginning on or after the date of the enactment of this Act [July 18, 1984], except that, in the case of individuals admitted to skilled nursing facilities before such date, the amendments made by such subsection shall not require recertifications sooner or more frequently than were required under the law in effect before such date.''

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §133(b), Sept. 3, 1982, 96 Stat. 374, provided that: ''The amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Sept. 3, 1982].''

Amendment by section 137(a)(1), (2) of Pub. L. 97–248 effective as if originally included in the provision of the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, to which such amendment relates, see section 137(d)(1) of Pub. L. 97–248, set out as a note under section 1396a of this title.

Amendment by section 137(b)(11)–(16), (27) 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.

Pub. L. 97–248, title I, §137(g), Sept. 3, 1982, 96 Stat. 381, provided that the amendment made by that section is effective Oct. 1, 1982.

Amendment by section 146(b) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2101(a)(2) of Pub. L. 97–35 applicable only to services furnished by a hospital during any accounting year beginning on or after Oct. 1, 1981, see section 2101(c) of Pub. L. 97–35, set out as an Effective Date note under section 1395uu of this title.

Pub. L. 97–35, title XXI, §2103(b)(2), Aug. 13, 1981, 95 Stat. 788, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to amounts expended on or after October 1, 1981.''

Amendment by section 2113(n) of Pub. L. 97–35 applicable to agreements with Professional Standards Review Organizations entered into on or after Oct. 1, 1981, see section 2113(*o*) of Pub. L. 97–35, set out as a note under section 1396a of this title.

Pub. L. 97–35, title XXI, §2161(c)(1), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97–248, title I, §137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided that the amendment made by such section 2161(c)(1) is effective for calendar quarters beginning on or after Oct. 1, 1984.

Pub. L. 97–35, title XXI, §2161(c)(2), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97–248, title I, §137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided that the amendment made by such section 2161(c)(2) is effective after payments for the first quarter of fiscal year 1985.

Pub. L. 97–35, title XXI, §2164(b), Aug. 13, 1981, 95 Stat. 806, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to tests occurring on or after October 1, 1981.''

Amendment by section 2174(b) of Pub. L. 97–35 applicable to services furnished on or after Oct. 1, 1981, see section 2174(c) of Pub. L. 97–35, set out as a note under section 1396a of this title.

Amendment by section 2178(a) of Pub. L. 97–35 applicable with respect to services furnished, under a State plan approved under this subchapter, on or before Oct. 1, 1981, except that such amendments not applicable with respect to services furnished by a health maintenance organization under a contract with a State entered into under this subchapter before Oct. 1, 1981, unless the organization requests that such amendments apply and the Secretary and the State agency agree to such request, see section 2178(c) of Pub. L. 97–35, set out as a note under section 1396a of this title.

Pub. L. 97–35, title XXI, §2183(b), Aug. 13, 1981, 95 Stat. 816, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to payments made to States for calendar quarters beginning on or after October 1, 1981.''

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §961(b), Dec. 5, 1980, 94 Stat. 2650, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to expenditures for services furnished on or after October 1, 1980.''

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 3(c)(2) of Pub. L. 95–142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 8(c) of Pub. L. 95–142 effective with respect to contracts, agreements, etc., made on and after the first day of the fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–5 of this title.

Pub. L. 95–142, §10(b), Oct. 25, 1977, 91 Stat. 1196, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after the date of the enactment of this Act [Oct. 25, 1977].''

Pub. L. 95–142, §11(c), Oct. 25, 1977, 91 Stat. 1197, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after January 1, 1978.''

Pub. L. 95–142, §17(e)(1), Oct. 25, 1977, 91 Stat. 1202, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after September 30, 1977.''

Pub. L. 95–142, §20(c), Oct. 25, 1977, 91 Stat. 1207, as amended by Pub. L. 95–292, §8(e), June 13, 1978, 92 Stat. 316, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396a of this title] shall be effective on October 1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act [42 U.S.C. 1396b] to reflect the changes made by such amendments.

''(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act [42 U.S.C. 1396b(g)(1)] because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section 1903(g) of such Act [42 U.S.C. 1396b(g)(4)(B)], as added by this section, shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1, 1977.''

Pub. L. 95–83, title I, §105(a)(3), Aug. 1, 1977, 91 Stat. 384, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to States for services provided—

''(A) after October 8, 1976, under contracts under such title [42 U.S.C. 1396 et seq.] entered into or renegotiated after such date, or

''(B) after the expiration of the one-year period beginning on such date,

whichever occurs first.''

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–552 effective Jan. 1, 1976, see section 2 of Pub. L. 94–552, set out as a note under section 1396a of this title.

Pub. L. 94–460, title II, § 202(b), Oct. 8, 1976, 90 Stat. 1959, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to States for services provided—

''(1) after the date of enactment of subsection (a) [Oct. 8, 1976] under contracts under such title entered into or renegotiated after such date, or

''(2) after the expiration of the 1-year period beginning on such date of enactment,

whichever occurs first.''

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, § 110(b), Dec. 31, 1975, 89 Stat. 1054, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the first day of the first calendar month which begins not less than 90 days after the date of enactment of this Act [Dec. 31, 1975].''

Amendment by section 111(b) of Pub. L. 94–182 effective January 1, 1976, except as otherwise provided therein, see section 111(c) of Pub. L. 94–182, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(11), (12) of Pub. L. 93–233 effective with respect to payments under this section 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.

Amendment by section 18(u) of Pub. L. 93–233 effective July 1, 1973, see section 18(z–3)(4) of Pub. L. 93–233, set out as a note under section 1396a of this title.

Pub. L. 93–66, title II, § 234(b), July 9, 1973, 87 Stat. 160, provided that: ''The amendment made by subsection (a) [amending this section] shall be applicable in the case of expenditures for skilled nursing services and for intermediate care facility services furnished in calendar quarters which begin after December 31, 1972.''

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 207(b), Oct. 30, 1972, 86 Stat. 1380, provided that: ''The amendments made by subsection (a) [amending this section] shall, except as otherwise provided therein, be effective July 1, 1973.''

Amendment by section 226(e) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 233(c) of Pub. L. 92–603 applicable with respect to services furnished by hospitals in accounting periods beginning after Dec. 31, 1972, see section 233(f) of Pub. L. 92–603, set out as a note under section 1395f of this title. See, also, section 16 of Pub. L. 93–233, set out as an Effective Date note under section 1395f of this title.

Pub. L. 92–603, title II, § 235(b), Oct. 30, 1972, 86 Stat. 1414, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], made after June 30, 1971.''

Pub. L. 92–603, title II, § 237(d)(1), Oct. 30, 1972, 86 Stat. 1416, provided that: ''The amendments made by subsections (a)(1) and (b) [amending this section and section 706 of this title] shall apply with respect to services furnished in calendar quarters beginning after June 30, 1973.''

Pub. L. 92–603, title II, § 249B, Oct. 30, 1972, 86 Stat. 1428, as amended by Pub. L. 93–368, § 8, Aug. 7, 1974, 88 Stat. 422; Pub. L. 95–83, title III, § 309(b), Aug. 1, 1977, 91 Stat. 396, provided that the amendment made by that section is effective for period beginning Oct. 1, 1972, and ending Sept. 30, 1980.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title II, § 220(b), Jan. 2, 1968, 81 Stat. 899, provided that:

''(b)(1) In the case of any State whose plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] is approved by the Secretary of Health, Education, and Welfare under section 1902 [42 U.S.C. 1396a] after July 25, 1967, the amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after the date of enactment of this Act [Jan. 2, 1968].

''(2) In the case of any State whose plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] was approved by the Secretary of Health, Education, and Welfare under section 1902 of the Social Security Act [42 U.S.C. 1396a] prior to July 26, 1967, amendments made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1968, except that—

''(A) with respect to the third and fourth calendar quarters of 1968, such subsection shall be applied by substituting in subsection (f) of section 1903 of the Social Security Act [42 U.S.C. 1396b(f)] 150 percent for 133⅓ percent each time such latter figure appears in such subsection (f), and

''(B) with respect to all calendar quarters during 1969, such subsection shall be applied by substituting in subsection (f) of section 1903 of such Act [42 U.S.C. 1396b(f)] 140 percent for 133⅓ percent each time such latter figure appears in such subsection (f).''

Pub. L. 90–248, title II, § 222(d), Jan. 2, 1968, 81 Stat. 901, as amended by Pub. L. 90–364, title III, § 303(a)(2), June 29, 1968, 82 Stat. 274, provided that the amendment made by such section 222(d) is effective with respect to calendar quarters beginning after December 31, 1969.

Pub. L. 90–248, title II, § 225(b), Jan. 2, 1968, 81 Stat. 902, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to expenditures made after December 31, 1967.''

Pub. L. 90–364, title III, § 303(b), June 29, 1968, 82 Stat. 274, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective with respect to calendar quarters beginning after December 31, 1967.''

REGULATIONS

Pub. L. 111–148, title VI, § 6506(b), Mar. 23, 2010, 124 Stat. 777, provided that: ''The Secretary [of Health and Human Services] shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.''

Pub. L. 102–234, § 5, Dec. 12, 1991, 105 Stat. 1804, provided that:

''(a) IN GENERAL.—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act [see Short Title of 1991 Amendment note set out under section 1305 of this title] and the amendments made by this Act.

''(b) REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act [42 U.S.C. 1396b(w)(6)(A)] (as added by section 2(a) of this Act) that are derived from donations or taxes that would

not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

''(c) CONSULTATION WITH STATES.—The Secretary shall consult with the States before issuing any regulations under this Act.''

Secretary of Health and Human Services to promulgate final regulations necessary to carry out subsec. (r)(6)(j) of this section within 6 months after Apr. 7, 1986, see section 9503(c) of Pub. L. 99–272, set out as a note under section 1396a of this title.

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.

IMPLEMENTATION OF SUBSECTIONS (i)(22) AND (x) REQUIREMENTS

Pub. L. 109–171, title VI, § 6036(c), Feb. 8, 2006, 120 Stat. 81, as amended by Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(v)(II), Dec. 20, 2006, 120 Stat. 3000, provided that: ''As soon as practicable after the date of enactment of this Act [Feb. 8, 2006], the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(22) and (x) of section 1903 of the Social Security Act [42 U.S.C. 1396b(i)(22), (x)] (as added by subsection (a)) about such requirements and how they may be satisfied.''

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by section 5005 of Pub. L. 114–255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114–255, set out as a note under section 1396a of this title.

Pub. L. 114–255, div. B, title XII, § 12006(c), Dec. 13, 2016, 130 Stat. 1277, provided that:

''(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section [amending this section] may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

''(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (*l*)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

''(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

''(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (*l*)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.''

CONSTRUCTION OF 2015 AMENDMENT

Pub. L. 114–113, div. O, title V, § 503(a)(2), Dec. 18, 2015, 129 Stat. 3021, provided that: ''Nothing in the amendments made by paragraph (1) [amending this section] shall be construed to prohibit a State Medicaid program from providing medical assistance for durable medical equipment for which payment is denied or not available under the Medicare program under title XVIII of such Act [act Aug. 14, 1935, ch. 531, 42 U.S.C. 1395 et seq.].''

SECURITY AND PRIVACY

Pub. L. 115–271, title I, § 1016(b), Oct. 24, 2018, 132 Stat. 3923, provided that: ''All applicable State and Federal security and privacy protections and laws shall apply to any State agency, individual, or entity accessing 1 or more prescription drug monitoring program databases or obtaining information in such databases in accordance with section 1903(m)(8) of the Social Security Act [42 U.S.C. 1396b(m)(8)] (as added by subsection (a)).''

COLLECTION AND DISSEMINATION OF BEST PRACTICES

Pub. L. 114–255, div. B, title XII, § 12006(b), Dec. 13, 2016, 130 Stat. 1277, provided that: ''Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (*l*)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to—

''(1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (*l*)(5)); and

''(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.''

CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS

Pub. L. 111–3, title VI, § 615, Feb. 4, 2009, 123 Stat. 102, provided that:

''(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act [42 U.S.C. 1396 et seq.] where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

''(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

''(1) provides level 1 trauma and burn care services;

''(2) provides level 3 neonatal care services;

''(3) is obligated to serve all patients, regardless of ability to pay;

''(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

''(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

''(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located.''

Pub. L. 108–173, title X, § 1001(e), Dec. 8, 2003, 117 Stat. 2431, provided that:

''(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be con-

strued by the Secretary [of Health and Human Services] as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act [42 U.S.C. 1396 et seq.] where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

''(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

''(A) provides level 1 trauma and burn care services;

''(B) provides level 3 neonatal care services;

''(C) is obligated to serve all patients, regardless of State of origin;

''(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

''(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

''(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act [42 U.S.C. 1396r–4] in at least one State other than the one in which the center is located.

''(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2005.''

TREATMENT OF DONATION OR TAX PROCEEDS PRIOR TO EFFECTIVE DATE OF SUBSECTION (w)

Pub. L. 102–234, § 2(c)(2), Dec. 12, 1991, 105 Stat. 1799, provided that: ''Except as specifically provided in section 1903(w) of the Social Security Act [42 U.S.C. 1396b(w)] and notwithstanding any other provision of such Act [42 U.S.C. 301 et seq.], the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure.''

TEMPORARY INCREASE IN FEDERAL MATCH FOR ADMINISTRATIVE COSTS

Pub. L. 101–508, title IV, § 4401(b)(2), Nov. 5, 1990, 104 Stat. 1388–159, provided that: ''The per centum to be applied under section 1903(a)(7) of the Social Security Act [42 U.S.C. 1396b(a)(7)] for amounts expended during calendar quarters in fiscal year 1991 which are attributable to administrative activities necessary to carry out section 1927 (other than subsection (g)) of such Act [42 U.S.C. 1396r–8] shall be 75 percent, rather than 50 percent; after fiscal year 1991, the match shall revert back to 50 percent.''

REPORT ON ERRORS IN ELIGIBILITY DETERMINATIONS; ERROR RATE TRANSITION RULES

Pub. L. 101–508, title IV, § 4607, Nov. 5, 1990, 104 Stat. 1388–170, directed Secretary of Health and Human Services to report to Congress, by not later than July 1, 1991, on error rates by States in determining eligibility of individuals described in subparagraph (A) or (B) of section 1396a(*l*)(1) of this title for medical assistance under plans approved under this subchapter, and directed that there should not be taken into account, for purposes of subsec. (u) of this section, payments and expenditures for medical assistance attributable to medical assistance for individuals described in such subparagraph (A) or (B), and made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the Secretary's report.

MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES

Pub. L. 101–508, title IV, § 4718, Nov. 5, 1990, 104 Stat. 1388–193, provided that:

''(a) IN GENERAL.—For purposes of section 1903(f)(1)(B) [probably means section 1903(f)(1)(B) of the Social Security Act, 42 U.S.C. 1396b(f)(1)(B)], for payments made before, on, or after the date of the enactment of this Act [Nov. 5, 1990], a State described in subparagraph (B) may use, in determining the 'highest amount which would ordinarily be paid to a family of the same size' (under the State's plan approved under part A of title IV of such Act [probably means 42 U.S.C. 601 et seq.]) in the case of a family consisting only of one individual and without regard to whether or not such plan provides for aid to families consisting only of one individual, an amount reasonably related to the highest money payment which would ordinarily be made under such a plan to a family of two without income or resources.

''(b) STATES COVERED.—Subsection (a) shall only apply to a State the State plan of which (under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) as of June 1, 1989, provided for the policy described in such paragraph. For purposes of the previous sentence, a State plan includes all the matter included in a State plan under section 2373(c)(5) of the Deficit Reduction Act of 1984 [Pub. L. 98–369, set out as a note under section 1396a of this title] (as amended by section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987 [Pub. L. 100–93]).''

DAY HABILITATION AND RELATED SERVICES

Pub. L. 101–239, title VI, § 6411(g), Dec. 19, 1989, 103 Stat. 2272, provided that:

''(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS.—Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not—

''(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act [42 U.S.C. 1396d(a)(9), (13)] on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

''(B) withdraw Federal approval of any such State plan provision.

''(2) REQUIREMENTS FOR REGULATION.—A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that—

''(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

''(B) any requirements respecting such coverage.

''(3) PROSPECTIVE APPLICATION OF REGULATION.—If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.''

NURSE AIDE TRAINING AND EVALUATION PROGRAMS; ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990

Pub. L. 101–239, title VI, § 6901(b)(5)(B), Dec. 19, 1989, 103 Stat. 2299, provided that: ''In making payments under section 1903(a)(2)(B) of the Social Security Act [42 U.S.C. 1396b(a)(2)(B)] for amounts expended for nurse aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such Act [42 U.S.C. 1396r(e)(1)], in the

case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act [42 U.S.C. 1395 et seq., 1396 et seq.].''

CLARIFICATION OF FEDERAL MATCHING RATE FOR SURVEY AND CERTIFICATION ACTIVITIES

Pub. L. 101–239, title VI, § 6901(d)(2), Dec. 19, 1989, 103 Stat. 2300, provided that: ''During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for so much of the sums expended under a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent.''

QUALITY CONTROL TRANSITION PROVISIONS

Pub. L. 100–485, title VI, § 608(h), Oct. 13, 1988, 102 Stat. 2424, provided that: ''There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act [42 U.S.C. 1396b(u)], payments and expenditures for medical assistance which are made on or after January 1, 1989, and before July 1, 1989, and which are attributable to medicare-cost [sic] sharing for qualified medicare beneficiaries (as defined in section 1905(p) of such Act [42 U.S.C. 1396d(p)]).''

DELAY QUALITY CONTROL SANCTIONS FOR MEDICAID

Pub. L. 100–203, title IV, § 4117, Dec. 22, 1987, 101 Stat. 1330–154, provided that: ''The Secretary of Health and Human Services shall not, prior to July 1, 1988, implement any reductions in payments to States pursuant to section 1903(u) of the Social Security Act [42 U.S.C. 1396b(u)] (or any provision of law described in subsection (c) of section 133 of the Tax Equity and Fiscal Responsibility Act of 1982 [section 133(c) of Pub. L. 97–248, set out below]).''

TEMPORARY TECHNICAL ERROR DEFINITION

Pub. L. 100–203, title IV, § 4118(n), Dec. 22, 1987, 101 Stat. 1330–157, provided that: ''For purposes of section 1903(u)(1)(E)(ii) of the Social Security Act [42 U.S.C. 1396b(u)(1)(E)(ii)], effective for the period beginning on the date of enactment of this Act [Dec. 22, 1987] and ending December 31, 1988, a 'technical error' is an error in eligibility condition (such as assignment of social security numbers and assignment of rights to third-party benefits as a condition of eligibility) that, if corrected, would not result in a difference in the amount of medical assistance paid.''

ENHANCED FUNDING FOR NURSE AIDE TRAINING

Pub. L. 100–203, title IV, § 4211(d)(2), Dec. 22, 1987, 101 Stat. 1330–204, as amended by Pub. L. 100–360, title IV, § 411(*l*)(3)(F), July 1, 1988, 102 Stat. 803, provided that: ''For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988), with respect to payment under section 1903(a)(2)(B) of the Social Security Act [42 U.S.C. 1396b(a)(2)(B)] to a State for additional amounts expended by the State under its plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such title [42 U.S.C. 1396r(e)(1)], any reference to '50 percent' is deemed a reference to the sum of the Federal medical assistance percentage (determined under section 1905(b) of such Act [42 U.S.C. 1396d(b)]) plus 25 percentage points, but not to exceed 90 percent.''

EXPENSES INCURRED FOR REVIEW OF CARE PROVIDED TO RESIDENTS OF NURSING FACILITIES

Pub. L. 100–203, title IV, § 4212(c)(3), Dec. 22, 1987, 101 Stat. 1330–212, provided that: ''For purposes of section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)], proper expenses incurred by a State for medical review by independent professionals of the care provided to residents of nursing facilities who are entitled to medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.] shall be reimbursable as expenses necessary for the proper and efficient administration of the State plan under that title.''

QUALITY CONTROL STUDIES AND PENALTY MORATORIUM

Pub. L. 99–272, title XII, § 12301, Apr. 7, 1986, 100 Stat. 291, as amended by Pub. L. 99–514, title XVII, § 1710, Oct. 22, 1986, 100 Stat. 2783; Pub. L. 100–485, title VI, § 609(b), Oct. 13, 1988, 102 Stat. 2425, provided that:

''(a) STUDIES.—(1) The Secretary of Health and Human Services (hereafter referred to in this section as the 'Secretary') shall conduct a study of quality control systems for the Aid to Families with Dependent Children Program under title IV–A of the Social Security Act [42 U.S.C. 601 et seq.] and for the Medicaid Program under title XIX of such Act [42 U.S.C. 1396 et seq.]. The study shall examine how best to operate such systems in order to obtain information which will allow program managers to improve the quality of administration, and provide reasonable data on the basis of which Federal funding may be withheld for States with excessive levels of erroneous payments.

''(2) The Secretary shall also contract with the National Academy of Sciences to conduct a concurrent independent study for the purpose described in paragraph (1). For purposes of such study, the Secretary shall provide to the National Academy of Sciences any relevant data available to the Secretary at the onset of the study and on an ongoing basis.

''(3) The Secretary and the National Academy of Sciences shall report the results of their respective studies to the Congress within one year after the date the Secretary and the National Academy of Sciences enter into the contract required under paragraph (2).

''(b) MORATORIUM ON PENALTIES.—(1) During the 24-month period beginning with the first calendar quarter which begins after the date of the enactment of this Act [Apr. 7, 1986] (hereafter in this section referred to as the 'moratorium period'), the Secretary shall not impose any reductions in payments to States pursuant to section 403(i) of the Social Security Act [42 U.S.C. 603(i)] (or prior regulations), or pursuant to any comparable provision of law relating to the programs under title IV–A of such Act [42 U.S.C. 601 et seq.] in Puerto Rico, Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands.

''(2) During the moratorium period, the Secretary and the States shall continue to operate the quality control systems in effect under title IV–A of the Social Security Act, and to calculate the error rates under the provisions referred to in paragraph (1).

''(c) RESTRUCTURED QUALITY CONTROL SYSTEMS.—(1) Not later than 6 months after the date on which the results of both studies required under subsection (a)(3) have been reported, the Secretary shall publish regulations which shall—

''(A) restructure the quality control systems under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to the extent the Secretary determines to be appropriate, taking into account the studies conducted under subsection (a); and

''(B) establish, taking into account the studies conducted under subsection (a), criteria for adjusting the reductions which shall be made for quarters prior to the implementation of the restructured quality control systems so as to eliminate reductions for those quarters which would not be required if the restructured quality control systems had been in effect during those quarters.

''(2) Beginning with the first calendar quarter after the moratorium period, the Secretary shall implement the revised quality control systems under title XIX, and shall reduce payments to States—

''(A) for quarters after the moratorium period in accordance with the restructured quality control systems; and

''(B) for quarters in and before the moratorium period, as provided under the regulations described in paragraph (1)(B).

''(d) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

EFFECTIVENESS OF LAWS LIMITING FEDERAL FINANCIAL PARTICIPATION WITH RESPECT TO ERRONEOUS PAYMENTS MADE BY STATES UNDER A STATE PLAN APPROVED UNDER THIS SUBCHAPTER

Pub. L. 97–248, title I, § 133(c), Sept. 3, 1982, 96 Stat. 374, provided that: ''No provision of law limiting Federal financial participation with respect to erroneous payments made by States under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations), other than the limitations contained in section 1903 of such Act [42 U.S.C. 1396b], shall be effective with respect to payments to States under such section 1903 for quarters beginning on or after October 1, 1982, unless such provision of law is enacted after the date of the date of the enactment of this Act [Sept. 3, 1982] and expressly provides that such limitation is in addition to or in lieu of the limitations contained in section 1903 of the Social Security Act.''

MEDICAID PAYMENTS FOR INDIAN HEALTH SERVICE FACILITIES TO BE PAID ENTIRELY BY FEDERAL FUNDS; EXCLUSION OF PAYMENTS TO STATES IN COMPUTATION OF TARGET AMOUNT OF FEDERAL MEDICAID EXPENDITURES

Pub. L. 97–92, §§ 102, 118, Dec. 15, 1981, 95 Stat. 1193, 1197, as amended by Pub. L. 97–161, Mar. 31, 1982, 96 Stat. 22, provided, for the period Dec. 15, 1981, to not later than Sept. 30, 1982, that: ''Notwithstanding section 1903(s) of the Social Security Act [42 U.S.C. 1396b(s)], all medicaid payments to the States for Indian health service facilities as defined by section 1911 of the Social Security Act [42 U.S.C. 1396j] shall be paid entirely by Federal funds, and notwithstanding section 1903(t) of the Social Security Act [42 U.S.C. 1396b(t)], all medicaid payments to the States for Indian health service facilities shall not be included in the computation of the target amount of Federal medicaid expenditures.''

PROMULGATION OF REGULATIONS FOR IMPLEMENTATION OF AMENDMENTS BY SECTION 17 OF PUB. L. 95–142

Pub. L. 95–142, § 17(e)(2), Oct. 25, 1977, 91 Stat. 1202, required Secretary of Health, Education, and Welfare to establish regulations, not later than 90 days after Oct. 25, 1977, to carry out amendments made by section 17 (amending sections 1395b–1 and 1396b of this title). See section 1302 of this title.

DEFERRAL OF IMPLEMENTATION OF DECREASES IN MATCHING FUNDS

Pub. L. 95–59, § 6, June 30, 1977, 91 Stat. 255, provided that: ''Notwithstanding the provisions of subsection (g) of section 1903 of the Social Security Act [42 U.S.C. 1396b(g)], the amount payable to any State for the calendar quarters during the period commencing April 1, 1977, and ending September 30, 1977, on account of expenditures made under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], shall not be decreased by reason of the application of the provisions of such subsection with respect to any period for which such State plan was in operation prior to April 1, 1977.''

COMPREHENSIVE CARE AND SERVICES FOR ELIGIBLE INDIVIDUALS BY JULY 1, 1977; REQUIREMENT INAPPLICABLE FOR ANY PERIOD PRIOR TO JULY 1, 1971; REGULATIONS; ADVICE TO STATES

Pub. L. 91–56, § 2(b), Aug. 9, 1969, 83 Stat. 99, which provided that subsection (e) of this section was inapplicable to the period prior to July 1, 1971, and which authorized the Secretary to issue regulations, was repealed by Pub. L. 92–603, title II, § 230, Oct. 30, 1972, 86 Stat. 1410.

EXEMPTION OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM FROM LIMITATIONS ON FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE

Pub. L. 90–248, title II, § 248(d), Jan. 2, 1968, 81 Stat. 919, provided that: ''The amendment made by section 220(a) of this Act [amending this section] shall not apply in the case of Puerto Rico, the Virgin Islands, or Guam.''

NONDUPLICATION OF PAYMENTS TO STATES; LIMITATION ON INSTITUTIONAL CARE

Pub. L. 89–97, title I, § 121(b), July 30, 1965, 79 Stat. 352, as amended by Pub. L. 92–603, title II, § 249D, Oct. 30, 1972, 86 Stat. 1429, provided that: ''No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act [42 U.S.C. 1396 et seq.], or for any period after December 31, 1969. After the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.] for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX.''

§ 1396b–1. Payment adjustment for health care-acquired conditions

(a) In general

The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall identify current State practices 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

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

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.)

Editorial Notes

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.)

Editorial Notes

CONSTITUTIONALITY

For information regarding the constitutionality of section 121(a) of Pub. L. 89–97, enacting this section, see the Table of Laws Held Unconstitutional in Whole or in Part by the Supreme Court on the Constitution Annotated website, constitution.congress.gov.

§ 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), 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, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI, 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,

(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,

(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,

(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,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI,

(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)),

(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,

[1] See References in Text note below.

(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)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (*l*)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (*l*)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3)(A) other laboratory and X-ray services; and

(B) in vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such in vitro diagnostic products;

(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)) 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[2] (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb)); and[2] (E) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and administration of the vaccine; and (F) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, without regard to the requirements of section 1396a(a)(10)(B) of this title (relating to comparability), in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan);

(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—

(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;

(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 sec-

[2] So in original. The word ''and'' probably should not appear.

tion 1396a(a)(31) of this title, to be in need of such care;

(16)(A) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h), and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph;

(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*));

(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));

(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), 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;

(29) subject to paragraphs (2) and (3) of subsection (ee), beginning on October 1, 2020, medication-assisted treatment (as defined in paragraph (1) of such subsection);

(30) subject to subsection (gg), routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial (as defined in such subsection);

(31) certified community behavioral health clinic services, as defined in subsection (jj); and

(32) 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 in the case of an eligible juvenile described in section 1396a(a)(84)(D) of this title with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section, or, at the option of the State, for an individual who is an eligible juvenile (as defined in section 1396a(nn)(2) of this title), while such individual is an inmate of a public institution (as defined in section 1396a(nn)(3) of this title) pending disposition of charges); 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 (except in the case of services provided under a State plan amendment described in section 1396n(*l*) of this title).

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), 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 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, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made

available to individuals described in section 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 who are not enrolled under part B of subchapter XVIII, 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. In the case of a woman who is eligible for medical assistance on the basis of being pregnant (including through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends), who is a patient in an institution for mental diseases for purposes of receiving treatment for a substance use disorder, and who was enrolled for medical assistance under the State plan immediately before becoming a patient in an institution for mental diseases or who becomes eligible to enroll for such medical assistance while such a patient, the exclusion from the definition of ''medical assistance'' set forth in the subdivision (B) following the last numbered paragraph of the first sentence of this subsection shall not be construed as prohibiting Federal financial participation for medical assistance for items or services that are provided to the woman outside of the institution.

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

Subject to subsections (y), (z), (aa), (ff), (hh), and (ii) 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 55 percent, (3) for purposes of this subchapter and subchapter XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (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, (5) in the case of a State that provides medical assistance for services described in subsection (a)(13)(A), and prohibits cost-sharing for such services, 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 for items and services described in subsection (a)(4)(D), and (6) during the first 8 fiscal quarters beginning on or after the effective date of this clause, in the case of a State which, as of August 16, 2022, provides medical assistance for vaccines described in subsection (a)(13)(B) and their administration and prohibits cost-sharing for such vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y), shall be increased by 1 percentage point with respect to medical assistance for such vaccines and their administration. 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 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603]); for the 8 fiscal year quarters beginning with the first fiscal year quarter beginning after March 11, 2021, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Urban Indian organization (as defined in paragraph (29) of section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603(29)]) that has a grant or contract with the Indian Health Service under title V of such Act [25 U.S.C. 1651 et seq.]; and, for such 8 fiscal year quarters, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through a Native Hawaiian Health Center (as defined in section 11711(4) of this title) or a qualified entity (as defined in section 11705(b) of this title) that has a grant or contract with the Papa Ola Lokahi under section 11707 of this title. Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1396r–4 of this title) described in subsection (u)(2)(A) or subsection (u)(3) 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. Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to (and, notwithstanding any other provision of this subchapter, available for) medical assistance provided to uninsured individuals (as defined in section 1396a(ss) of this title) who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XXIII) of this title and with respect to expenditures described in section 1396b(a)(7) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs related to providing for such medical assistance to such individuals under the State plan.

(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)) 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), 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 institution 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 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 So-

cial 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, 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.

***(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 an[3] 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, 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. 5321 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),[4] 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)) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV pursuant to section 607[1] 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—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of subchapter IV (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV 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 pursuant to section

[3] So in original. Probably should be ''a''.

[4] So in original. Probably should be clause ''(iii),''. See References in Text note below.

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; 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.

(*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 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 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 (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) or who is enrolled under part B for the purpose of coverage of immunosuppressive drugs under section 1395*o*(b) 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, 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 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,[5]

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

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

(D) The difference between the amount that is paid under section 1395*l*(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)[6] or[7] 1396a(a)(10)(E)(iii) of this title of such paragraph[6] 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—

(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,

(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

[5] So in original. The comma probably should be a period.

[6] So in original. The words ''of such paragraph'' probably should follow ''subparagraph (B)''.

[7] So in original. Probably should be ''or section''.

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 (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) 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 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; 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));

(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).

(2)(A) For purposes of subsection (b), 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), 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 before the date the individuals attained 18 years of age.

(x) Strategies, treatment, and services

For purposes of subsection (a)(27), 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.[8]

[8] So in original.

(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 nonpregnant 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 nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

(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 State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year 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, subsections (y) and (z), 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 State's regular FMAP for such fiscal year shall be increased by 25 percent (or 50 percent in the case of fiscal year 2013) of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.

(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 State's regular FMAP for the fiscal year 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, subsections (y) and (z), 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 State's regular FMAP for the fiscal year 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) In this subsection, the term ''regular FMAP'' means, for each fiscal year for which this subsection applies to a State, the Federal medical assistance percentage that would otherwise apply to the State for the fiscal year, as determined under subsection (b) and without regard to this subsection, subsections (y) and (z), and section 10202 of the Patient Protection and Affordable Care Act.

(4) 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)[9] 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

[9] So in original. Probably should be preceded by ''section''.

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 political 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 and section 6008 of the Families First Coronavirus Response Act, except that in applying such treatments to the increases in the Federal medical assistance percentage under section 6008 of the Families First Coronavirus Response Act, the reference to ''December 31, 2009'' shall be deemed to be a reference to ''March 11, 2020''.

(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.

(ee) Medication-assisted treatment

(1) Definition

For purposes of subsection (a)(29), the term ''medication-assisted treatment''—

(A) means all drugs approved under section 355 of title 21, including methadone, and all biological products licensed under section 262 of this title to treat opioid use disorders; and

(B) includes, with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

(2) Exception

The provisions of paragraph (29) of subsection (a) shall not apply with respect to a State if such State certifies, not less than every 5 years and to the satisfaction of the Secretary, that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1396b(m) of this title or under section 1396d(t)(3) of this title.

(3) Application of rebate requirements

The requirements of section 1396r–8 of this title shall apply to any drug or biological product described in paragraph (1)(A) that is—

(A) furnished as medical assistance in accordance with subsection (a)(29) and section 1396a(a)(10)(A) of this title; and

(B) a covered outpatient drug (as defined in section 1396r–8(k) of this title, except that, in applying paragraph (2)(A) of such section to a drug described in paragraph (1)(A), such drug shall be deemed a prescribed drug for purposes of subsection (a)(12)).

(ff) Increase in FMAP for territories for certain fiscal years

Notwithstanding subsection (b) or (z)(2), subject to subsections (hh) and (ii)—

(1) for the period beginning October 1, 2019, and ending December 20, 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 100 percent;

(2) for the period beginning December 21, 2019, and ending December 3, 2021, and for the period beginning January 1, 2022, and ending September 30, 2027, the Federal medical assistance percentage for Puerto Rico shall be equal to 76 percent; and

(3) subject to section 1308(g)(8)(B) of this title, beginning December 21, 2019, the Federal medical assistance percentage for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 83 percent.

(gg)(1) Routine patient costs

For purposes of subsection (a)(30), with respect to a State and an individual enrolled under the State plan (or a waiver of such plan) who participates in a qualifying clinical trial, routine patient costs—

(A) include any item or service provided to the individual under the qualifying clinical trial, including—

(i) any item or service provided to prevent, diagnose, monitor, or treat complications resulting from such participation, to the extent that the provision of such an item or service to the individual outside the course of such participation would otherwise be covered under the State plan or waiver; and

(ii) any item or service required solely for the provision of the investigational item or service that is the subject of such trial, including the administration of such investigational item or service; and

(B) does not include—

(i) an item or service that is the investigational item or service that is—

(I) the subject of the qualifying clinical trial; and

(II) not otherwise covered outside of the clinical trial under the State plan or waiver; or

(ii) an item or service that is—

(I) provided to the individual solely to satisfy data collection and analysis needs for the qualifying clinical trial and is not used in the direct clinical management of the individual; and

(II) not otherwise covered under the State plan or waiver.

(2) Qualifying clinical trial defined

(A) In general

For purposes of this subsection and subsection (a)(30), the term ''qualifying clinical trial'' means a clinical trial (in any clinical phase of development) that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of the following clauses:

(i) The study or investigation is approved, conducted, or supported (which may include funding through in-kind contributions) by one or more of the following:

(I) The National Institutes of Health.

(II) The Centers for Disease Control and Prevention.

(III) The Agency for Healthcare Research and Quality.

(IV) The Centers for Medicare & Medicaid Services.

(V) A cooperative group or center of any of the entities described in subclauses (I) through (IV) or the Department of Defense or the Department of Veterans Affairs.

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(VII) Any of the following if the conditions described in subparagraph (B) are met:

(aa) The Department of Veterans Affairs.

(bb) The Department of Defense.

(cc) The Department of Energy.

(ii) The clinical trial is conducted pursuant to an investigational new drug exemption under section 355(i) of title 21 or an exemption for a biological product undergoing investigation under section 262(a)(3) of this title.

(iii) The clinical trial is a drug trial that is exempt from being required to have an exemption described in clause (ii).

(B) Conditions

For purposes of subparagraph (A)(i)(VII), the conditions described in this subparagraph, with respect to a clinical trial approved or funded by an entity described in such subparagraph (A)(i)(VII), are that the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines—

(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(ii) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

(3) Coverage determination requirements

A determination with respect to coverage under subsection (a)(30) for an individual participating in a qualifying clinical trial—

(A) shall be expedited and completed within 72 hours;

(B) shall be made without limitation on the geographic location or network affiliation of the health care provider treating such individual or the principal investigator of the qualifying clinical trial;

(C) shall be based on attestation regarding the appropriateness of the qualifying clinical trial by the health care provider and principal investigator described in subparagraph (B), which shall be made using a streamlined, uniform form developed for State use by the Secretary and that includes the option to reference information regarding the qualifying clinical trial that is publicly available on a website maintained by the Secretary, such as clinicaltrials.gov (or a successor website); and

(D) shall not require submission of the protocols of the qualifying clinical trial, or any

other documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

(hh) Temporary increased FMAP for medical assistance for coverage and administration of COVID–19 vaccines

(1) In general

Notwithstanding any other provision of this subchapter, during the period described in paragraph (2), the Federal medical assistance percentage for a State, with respect to amounts expended by the State for medical assistance for a vaccine described in subsection (a)(4)(E) (and the administration of such a vaccine), shall be equal to 100 percent.

(2) Period described

The period described in this paragraph is the period that—

(A) begins on the first day of the first quarter beginning after March 11, 2021; and

(B) ends on the last day of the first quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title.

(3) Exclusion of expenditures from territorial caps

Any payment made to a territory for expenditures for medical assistance under subsection (a)(4)(E) that are subject to the Federal medical assistance percentage specified under paragraph (1) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1308 of this title.

(ii) Temporary increase in FMAP for medical assistance under State medicaid plans which begin to expend amounts for certain mandatory individuals

(1) In general

For each quarter occurring during the 8-quarter period beginning with the first calendar quarter during which a qualifying State (as defined in paragraph (3)) expends amounts for all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title under the State plan (or waiver of such plan), the Federal medical assistance percentage determined under subsection (b) for such State shall, after application of any increase, if applicable, under section 6008 of the Families First Coronavirus Response Act, be increased by 5 percentage points, except for any quarter (and each subsequent quarter) during such period during which the State ceases to provide medical assistance to any such individual under the State plan (or waiver of such plan).

(2) Special application rules

Any increase described in paragraph (1) (or payment made for expenditures on medical assistance that are subject to such increase)—

(A) shall not apply with respect to disproportionate share hospital payments described in section 1396r–4 of this title;

(B) shall not be taken into account in calculating the enhanced FMAP of a State under section 1397ee of this title;

(C) shall not be taken into account for purposes of part A, D, or E of subchapter IV; and

(D) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1308 of this title.

(3) Definition

For purposes of this subsection, the term ''qualifying State'' means a State which has not expended amounts for all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title before March 11, 2021.

(jj) Certified community behavioral health clinic services

(1) In general

The term ''certified community behavioral health services'' means any of the following services when furnished to an individual as a patient of a certified community behavioral health clinic (as defined in paragraph (2)), in a manner reflecting person-centered care and which, if not available directly through a certified community behavioral health clinic, may be provided or referred through formal relationships with other providers:

(A) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(B) Screening, assessment, and diagnosis, including risk assessment.

(C) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(D) Outpatient mental health and substance use services.

(E) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(F) Intensive case management services.

(G) Psychiatric rehabilitation services.

(H) Peer support and counselor services and family supports.

(I) Intensive, community-based mental health care for members of the armed forces and veterans who are eligible for medical assistance, particularly such members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

(2) Certified community behavioral health clinic

The term ''certified community behavioral health clinic'' means an organization that—

(A) has been certified by a State as meeting the criteria established by the Secretary pursuant to subsection (a) of section 223 of the Protecting Access to Medicare Act[1] as of January 1, 2024, and any subsequent updates to such criteria, regardless of whether the State is carrying out a demonstration program under this subchapter under subsection (d) of such section;

(B) is engaged in furnishing all of the services described in paragraph (1); and

(C) agrees, as a condition of the certification described in subparagraph (A), to fur-

nish to the State or Secretary any data required as part of ongoing monitoring of the organization's provision of services, including encounter data, clinical outcomes data, quality data, and such other data as the State or Secretary may require.

(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)–(18), 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, 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; Pub. L. 112–96, title III, § 3204(a), Feb. 22, 2012, 126 Stat. 193; Pub. L. 112–141, div. F, title I, § 100123(b), July 6, 2012, 126 Stat. 915; Pub. L. 114–255, div. B, title XII, § 12005(a), Dec. 13, 2016, 130 Stat. 1275; Pub. L. 115–271, title I, §§ 1006(b)(2), (3), 1012(a), title V, § 5052(a)(1), Oct. 24, 2018, 132 Stat. 3914, 3919, 3971; Pub. L. 116–59, div. B, title III, § 1302, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title III, § 1302, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, § 202(c), Dec. 20, 2019, 133 Stat. 3107; Pub. L. 116–127, div. F, §§ 6004(a)(1), (3)(D), 6008(c), Mar. 18, 2020, 134 Stat. 204, 206, 209; Pub. L. 116–136, div. A, title III, § 3717, Mar. 27, 2020, 134 Stat. 425; Pub. L. 116–159, div. C, title VI, § 2601(a), Oct. 1, 2020, 134 Stat. 738; Pub. L. 116–260, div. CC, title II, § 210(a), title IV, § 402(f)(1), Dec. 27, 2020, 134 Stat. 2989, 3001; Pub. L. 117–2, title IX, §§ 9811(a)(1), (b), 9814, 9815, Mar. 11, 2021, 135 Stat. 208, 211, 215; Pub. L. 117–43, div. D, title I, § 3105(a), Sept. 30, 2021, 135 Stat. 380; Pub. L. 117–70, div. C, title I, § 2104(a), Dec. 3, 2021, 135 Stat. 1504; Pub. L. 117–86, div. B, title I, § 1104(a), Feb. 18, 2022, 136 Stat. 17; Pub. L. 117–103, div. P, title II, § 201(a), Mar. 15, 2022, 136 Stat. 802; Pub. L. 117–169, title I, § 11405(a)(3), Aug. 16, 2022, 136 Stat. 1901; Pub. L. 117–180, div. D, title I, § 103, Sept. 30, 2022, 136 Stat. 2135; Pub. L. 117–229, div. C, title I, § 103, Dec. 16, 2022, 136 Stat. 2311; Pub. L. 117–328, div. FF, title V, §§ 5101(b), 5121(b), 5122(a)(1), Dec. 29, 2022, 136 Stat. 5934, 5942, 5943; Pub. L. 118–42, div. G, title I, §§ 201(a), 205(c)(3), (4), 209(a), Mar. 9, 2024, 138 Stat. 399, 406, 412.)

Editorial Notes

REFERENCES IN TEXT

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).

The Indian Health Care Improvement Act, referred to in subsecs. (b) and (*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.

For the effective date of this clause, referred to in subsec. (b)(6), see Effective Date of 2022 Amendment note set out under section 1396a of this title.

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 was classified principally to part A (§ 450f et seq.) of subchapter II of chapter 14 of Title 25, Indians, prior to editorial reclassification as subchapter I (§ 5321 et seq.) of chapter 46 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 5301 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 and section 5001 of the American Recovery and Reinvestment Act of 2009, referred to in subsecs. (aa)(1)(A), (2)(A), and (cc), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly 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 10202 of the Patient Protection and Affordable Care Act, referred to in subsec. (aa)(3), is section 10202 of Pub. L. 111–148, which is set out as a note under this section.

Section 6008 of the Families First Coronavirus Response Act, referred to in subsecs. (cc) and (ii)(1), is section 6008 of Pub. L. 116–127, which amended this section and enacted provisions set out as a note under this section.

Section 223 of the Protecting Access to Medicare Act, referred to in subsec. (jj)(2)(A), probably means section 223 of Pub. L. 113–93, known as the Protecting Access to Medicare Act of 2014, which is set out as a note under section 1396a of this title.

AMENDMENTS

2024—Subsec. (a). Pub. L. 118–42, § 205(c)(4), substituted ''the last numbered paragraph'' for ''paragraph (30)'' in concluding provisions.

Pub. L. 118–42, § 205(c)(3), made technical amendment to directory language of Pub. L. 117–328, § 5122(a)(1). See 2022 Amendment note below.

Subsec. (a)(29). Pub. L. 118–42, § 201(a)(1), substituted ''beginning on October 1, 2020,'' for ''for the period beginning October 1, 2020, and ending September 30, 2025,''.

Subsec. (a)(31), (32). Pub. L. 118–42, § 209(a)(1), added par. (31) and redesignated former par. (31) as (32).

Subsec. (ee)(2). Pub. L. 118–42, § 201(a)(2), substituted ''if such State certifies, not less than every 5 years and to the satisfaction of the Secretary,'' for ''for the period specified in such paragraph, if before the beginning of such period the State certifies to the satisfaction of the Secretary''.

Subsec. (jj). Pub. L. 118–42, § 209(a)(2), added subsec. (jj).

2022—Subsec. (a). Pub. L. 117–328, § 5122(a)(1), as amended by Pub. L. 118–42, § 205(c)(3), in subd. (A) following par. (32), inserted '', or, at the option of the State, for an individual who is an eligible juvenile (as defined in section 1396a(nn)(2) of this title), while such individual is an inmate of a public institution (as defined in section 1396a(nn)(3) of this title) pending disposition of charges'' after ''or in the case of an eligible juvenile described in section 1396a(a)(84)(D) of this title with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section''.

Pub. L. 117–328, § 5121(b), in subd. (A) following par. (31), inserted '', or in the case of an eligible juvenile described in section 1396a(a)(84)(D) of this title with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section'' after ''(except as a patient in a medical institution''.

Subsec. (b). Pub. L. 117–169, § 11405(a)(3)(A)–(C), substituted ''(5) in the case of'' for ''and (5) in the case of'', ''services described in subsection (a)(13)(A), and prohibits cost-sharing for such services'' for ''services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines'', and ''medical assistance for such services'' for ''medical assistance for such services and vaccines''.

Subsec. (b)(6). Pub. L. 117–169, § 11405(a)(3)(D), inserted '', and (6) during the first 8 fiscal quarters beginning on or after the effective date of this clause, in the case of a State which, as of August 16, 2022, provides medical assistance for vaccines described in subsection (a)(13)(B) and their administration and prohibits cost-sharing for such vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y), shall be increased by 1 percentage point with respect to medical assistance for such vaccines and their administration'' before the first period.

Subsec. (ff). Pub. L. 117–328, § 5101(b)(1), struck out ''Temporary'' before ''increase in FMAP'' in heading.

Subsec. (ff)(2). Pub. L. 117–328, § 5101(b)(2), struck out ''subject to section 1308(g)(7)(C) of this title,'' before ''for the period beginning December 21, 2019,'' and substituted ''September 30, 2027,'' for ''December 23, 2022''.

Pub. L. 117–229, § 103(1), substituted ''December 23, 2022'' for ''December 16, 2022''.

Pub. L. 117–180 substituted ''December 16'' for ''December 13''.

Pub. L. 117–103, § 201(a)(1), inserted ''and for the period beginning January 1, 2022, and ending December 13, 2022'' after ''and ending December 3, 2021,''.

Subsec. (ff)(3). Pub. L. 117–328, § 5101(b)(3), substituted ''beginning December 21, 2019'' for ''for the period beginning December 21, 2019, and ending December 23, 2022''.

Pub. L. 117–229, § 103(2), substituted ''December 23, 2022'' for ''December 16, 2022''.

Pub. L. 117–180 substituted ''December 16'' for ''December 13''.

Pub. L. 117–103, § 201(a)(2), substituted ''December 13, 2022'' for ''March 11, 2022''.

Pub. L. 117–86 substituted ''March 11, 2022'' for ''February 18, 2022''.

2021—Subsec. (a)(4). Pub. L. 117–2, § 9811(a)(1), added cls. (E) and (F).

Subsec. (b). Pub. L. 117–2, § 9815, inserted ''; for the 8 fiscal year quarters beginning with the first fiscal year quarter beginning after March 11, 2021, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Urban Indian organization (as defined in paragraph (29) of section 4 of the Indian Health Care Improvement Act) that has a grant or contract with the Indian Health Service under title V of such Act; and, for such 8 fiscal year quarters, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through a Native Hawaiian Health Center (as defined in section 11711(4) of this title) or a qualified entity (as defined in section 11705(b) of this title) that has a grant or contract with the Papa Ola Lokahi under section 11707 of this title'' after ''(as defined in section 4 of the Indian Health Care Improvement Act)''.

Pub. L. 117–2, § 9814(1), substituted ''(hh), and (ii)'' for ''and (hh)''.

Pub. L. 117–2, § 9811(b)(1), substituted ''(ff), and (hh)'' for ''and (ff)''.

Subsec. (ff). Pub. L. 117–43 substituted ''December 3, 2021'' for ''September 30, 2021'' in two places.

Pub. L. 117–2, § 9814(2), substituted ''subject to subsections (hh) and (ii)'' for ''subject to subsection (hh)'' in introductory provisions.

Pub. L. 117–2, § 9811(b)(2), inserted '', subject to subsection (hh)'' after ''or (z)(2)'' in introductory provisions.

Subsec. (ff)(3). Pub. L. 117–70 substituted ''February 18, 2022'' for ''December 3, 2021''.

Subsec. (hh). Pub. L. 117–2, § 9811(b)(3), added subsec. (hh).

Subsec. (ii). Pub. L. 117–2, § 9814(3), added subsec. (ii).

2020—Subsec. (a)(3)(A). Pub. L. 116–127, § 6004(a)(1)(A), (B), designated existing provisions as subpar. (A) and inserted ''and'' at end.

Subsec. (a)(3)(B). Pub. L. 116–136 struck out ''that are approved, cleared, or authorized under section 360(k), 360c, 360e or 360bbb–3 of title 21'' after ''that causes COVID–19''.

Pub. L. 116–127, § 6004(a)(1)(C), added subpar. (B).

Subsec. (a)(29). Pub. L. 116–159, § 2601(a)(1), substituted ''subject to paragraphs (2) and (3)'' for ''subject to paragraph (2)'' and realigned margins.

Subsec. (a)(30), (31). Pub. L. 116–260, § 210(a)(1), added par. (30) and redesignated former par. (30) as (31).

Subsec. (b). Pub. L. 116–127, § 6004(a)(3)(D), inserted at end ''Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to (and, notwithstanding any other provision of this subchapter, available for) medical assistance provided to uninsured individuals (as defined in section 1396a(ss) of this title) who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XXIII) of this title and with respect to expenditures described in section 1396b(a)(7) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs related to providing for such medical assistance to such individuals under the State plan.''

Subsec. (p)(1)(A). Pub. L. 116–260, § 402(f)(1), inserted ''or who is enrolled under part B for the purpose of coverage of immunosuppressive drugs under section 1395*o*(b) of this title'' after ''under section 1395i–2a of this title)''.

Subsec. (cc). Pub. L. 116–127, § 6008(c), inserted before period at end ''and section 6008 of the Families First Coronavirus Response Act, except that in applying such treatments to the increases in the Federal medical assistance percentage under section 6008 of the Families First Coronavirus Response Act, the reference to 'December 31, 2009' shall be deemed to be a reference to 'March 11, 2020' ''.

Subsec. (ee)(3). Pub. L. 116–159, § 2601(a)(2), added par. (3).

Subsec. (gg). Pub. L. 116–260, § 210(a)(2), added subsec. (gg).

2019—Subsec. (b). Pub. L. 116–59, § 1302(1), substituted ''(aa), and (ff)'' for ''and (aa)''.

Subsec. (ff). Pub. L. 116–94 amended subsec. (ff) generally. Prior to amendment, text read as follows: ''Notwithstanding subsection (b) or (z)(2), the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 100 percent for the period beginning October 1, 2019, and ending December 20, 2019.''

Pub. L. 116–69 substituted ''December 20, 2019'' for ''November 21, 2019''.

Pub. L. 116–59, § 1302(2), added subsec. (ff).

2018—Subsec. (a). Pub. L. 115–271, § 5052(a)(1), in subd. (B) following par. (30), inserted ''(except in the case of services provided under a State plan amendment described in section 1396n(*l*) of this title)'' before period at end.

Pub. L. 115–271, § 1012(a), inserted at end ''In the case of a woman who is eligible for medical assistance on the basis of being pregnant (including through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends), who is a patient in an institution for mental diseases for purposes of receiving treatment for a substance use disorder, and who was enrolled for medical assistance under the State plan immediately before becoming a patient in an institution for mental diseases or who becomes eligible to enroll for such medical assistance while such a patient, the exclusion from the definition of 'medical assistance' set forth in the subdivision (B) following paragraph (30) of the first sentence of this subsection shall not be construed as prohibiting Federal financial participation for medical assistance for items or services that are provided to the woman outside of the institution.''

Subsec. (a)(29), (30). Pub. L. 115–271, § 1006(b)(2), added par. (29) and redesignated former par. (29) as (30).

Subsec. (ee). Pub. L. 115–271, § 1006(b)(3), added subsec. (ee).

2016—Subsec. (a)(16). Pub. L. 114–255 substituted ''(A) effective January 1, 1973'' for ''effective January 1, 1973'' and inserted before semicolon at end '', and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph''.

2012—Subsec. (aa)(1)(A). Pub. L. 112–96, § 3204(a)(1)(A), substituted ''the State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year 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, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111–5.'' for ''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.''

Subsec. (aa)(1)(B). Pub. L. 112–141 substituted ''25 percent (or 50 percent in the case of fiscal year 2013)'' for ''25 percent''.

Pub. L. 112–96, § 3204(a)(1)(B), substituted ''State's regular FMAP for such fiscal year shall be increased by 25 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.'' for ''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.''

Subsec. (aa)(2)(A). Pub. L. 112–96, § 3204(a)(2)(A), substituted ''State's regular FMAP for the fiscal year'' for ''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,'' and ''subsections (y) and (z)'' for ''subsection (y)''.

Subsec. (aa)(2)(B). Pub. L. 112–96, § 3204(a)(2)(B), substituted ''State's regular FMAP for the fiscal year'' for ''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,''.

Subsec. (aa)(3), (4). Pub. L. 112–96, §3204(a)(3), (4), added par. (3) and redesignated former par. (3) as (4).

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 cl. (D).

Subsec. (a)(13). Pub. L. 111–148, §4106(a), amended par. (13) generally. Prior to amendment, par. (13) read as follows: ''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;''.

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, §4106(b), substituted '', (4)'' for ''and (4)'' and inserted before period at end of first sentence '', 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)''.

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

Pub. L. 111–148, §2005(c)(1), substituted ''shall be 55 percent'' for ''shall be 50 per centum'' 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 indi-

viduals 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 allotment for such fiscal year,'' after ''subsection (u)(3)''.

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), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) 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, 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)'' 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 location; 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 from 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 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, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 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 who are not enrolled under part B of subchapter XVIII, 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'' 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 1395*l*(b) of this title)'' for ''section 1395e of this title, section 1395*l*(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 1395*l*(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), 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, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI'' 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''.

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,'' 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,'' 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); and'' for ''under 21, as defined in subsection (e);''.

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 ''(ii)'' 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), and relating to skilled nursing facility, 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, § 299L(b), added subsec. (h) relating to skilled nursing facility.

Pub. L. 92–603, § 299B(b), added subsec. (h) relating to inpatient psychiatric hospital services for individuals under age 21.

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, or part A of subchapter IV'' 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''.

Statutory Notes and Related Subsidiaries

Effective Date of 2024 Amendment

Pub. L. 118–42, div. G, title I, § 209(b), Mar. 9, 2024, 138 Stat. 413, provided that: ''The amendments made by this section [amending this section] shall apply with respect to medical assistance furnished on or after the date of enactment of this Act [Mar. 9, 2024].''

Effective Date of 2022 Amendment

Amendment by section 5121(b) of Pub. L. 117–328 applicable beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after Dec. 29, 2022, see section 5121(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

Amendment by section 5122(a)(1) of Pub. L. 117–328 effective on the first day of the first calendar quarter that begins after the date that is 24 months after Dec. 29, 2022, and applicable to items and services furnished for periods beginning on or after such date, see section 5122(c) of Pub. L. 117–328, set out as a note under section 1396a of this title.

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the

date that is 1 year after Aug. 16, 2022, and applicable to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 210(a) of Pub. L. 116–260 applicable with respect to items and services furnished on or after Jan. 1, 2022, see section 210(e) of Pub. L. 116–260, set out as a note under section 1308 of this title.

Pub. L. 116–159, div. C, title VI, §2601(c), Oct. 1, 2020, 134 Stat. 738, provided that: ''The amendments made by this section [amending this section and section 1396r–8 of this title] shall take effect as if included in the enactment of section 1006(b) of the SUPPORT for Patients and Communities Act (Public Law 115–271; 132 Stat. 3914).''

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 1006(b)(2), (3) of Pub. L. 115–271 applicable with respect to medical assistance provided on or after Oct. 1, 2020, and before Oct. 1, 2025, with exception if State legislation required, see section 1006(b)(4) of Pub. L. 115–271, set out as a note under section 1396a of this title.

Pub. L. 115–271, title I, §1012(b), Oct. 24, 2018, 132 Stat. 3920, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Oct. 24, 2018].

''(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements 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 these additional requirements 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. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. B, title XII, §12005(b), Dec. 13, 2016, 130 Stat. 1275, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to items and services furnished in calendar quarters beginning on or after January 1, 2019.''

EFFECTIVE DATE OF 2012 AMENDMENT

Pub. L. 112–141, div. F, title I, §100123(c), July 6, 2012, 126 Stat. 915, provided that: ''The amendments made by this section [amending this section and provisions set out as a note under this section] shall be effective as if included in the enactment of section 3204 of Public Law 112–96.''

Pub. L. 112–96, title III, §3204(b), Feb. 22, 2012, 126 Stat. 194, as amended by Pub. L. 112–141, div. F, title I, §100123(a), July 6, 2012, 126 Stat. 915, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2012.''

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 1396*o*, 1396*o*–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 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, 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.

Pub. L. 105–33, title IV, §4712(d)(2), Aug. 5, 1997, 111 Stat. 509, 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.

Pub. L. 105–33, title IV, §4725(b)(2), Aug. 5, 1997, 111 Stat. 518, 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.

Pub. L. 103–66, title XIII, §13605(b), Aug. 10, 1993, 107 Stat. 621, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to servics furnished on or after October 1, 1993.''

Pub. L. 103–66, title XIII, §13606(b), Aug. 10, 1993, 107 Stat. 621, 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.

Pub. L. 103–66, title XIII, §13631(g)(2), Aug. 10, 1993, 107 Stat. 645, 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 [sic] (A)(i) and subparagraph (B)(iii) of section 1905(r)(1) of the Social Security Act [42 U.S.C. 1396d(r)(1)(A)(i), (B)(iii)] (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.

Pub. L. 101–508, title IV, §4705(b), Nov. 5, 1990, 104 Stat. 1388–173, provided that: ''The amendments made by subsection (a) [amending this section] shall be effec-

tive 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.

Pub. L. 101–508, title IV, §4719(b), Nov. 5, 1990, 104 Stat. 1388–193, 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].''

Pub. L. 101–508, title IV, §4721(b), Nov. 5, 1990, 104 Stat. 1388–194, 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.''

Pub. L. 101–508, title IV, §4755(a)(1)(B), Nov. 5, 1990, 104 Stat. 1388–209, 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 AMENDMENT

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 AMENDMENT

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.

Pub. L. 100–360, title IV, §411(k)(14)(B), July 1, 1988, 102 Stat. 799, 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.

Pub. L. 100–203, title IV, §4101(c)(3), Dec. 22, 1987, 101 Stat. 1330–141, 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 [42 U.S.C. 1396d(n)(2)] (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'.''

Pub. L. 100–203, title IV, §4103(b), Dec. 22, 1987, 101 Stat. 1330–146, 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].''

Pub. L. 100–203, title IV, § 4105(b), Dec. 22, 1987, 101 Stat. 1330–147, 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 1396r 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 AMENDMENT

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.

Pub. L. 99–272, title IX, § 9501(d)(1), Apr. 7, 1986, 100 Stat. 202, 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 [42 U.S.C. 1396 et seq.] 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.

Pub. L. 99–272, title IX, § 9511(b), Apr. 7, 1986, 100 Stat. 212, 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.

Pub. L. 98–369, div. B, title III, § 2371(b), July 18, 1984, 98 Stat. 1110, 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

Pub. L. 95–292, § 8(d)(1), June 13, 1978, 92 Stat. 316, 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

Pub. L. 92–603, title II, § 212(b), Oct. 30, 1972, 86 Stat. 1384, provided that: ''The provisions of subsection (e) of

section 1905 of the Social Security Act [42 U.S.C. 1396d(e)] (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.

Pub. L. 92–603, title II, § 275(b), Oct. 30, 1972, 86 Stat. 1452, provided that: ''The amendment made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973.''

Pub. L. 92–603, title II, § 297(b), Oct. 30, 1972, 86 Stat. 1460, 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

Pub. L. 90–248, title II, § 248(e), Jan. 2, 1968, 81 Stat. 919, 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 [42 U.S.C. 1396 et seq.] 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 [42 U.S.C. 1396d(r)].''

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.

REVIEW OF STATE IMPLEMENTATION OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES

Pub. L. 117–159, div. A, title I, § 11004, June 25, 2022, 136 Stat. 1319, provided that:

''(a) REVIEW.—

''(1) IN GENERAL.—Not later than 24 months after the date of enactment of Act [probably means ''this Act'', June 25, 2022], and every 5 years thereafter, the Secretary shall—

''(A) review State implementation of the requirements for providing early and periodic screening, diagnostic, and treatment services under Medicaid in accordance with sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)), including with respect to the provision of such services by managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers;

''(B) identify gaps and deficiencies with respect to State compliance with such requirements;

''(C) provide technical assistance to States to address such gaps and deficiencies; and

''(D) issue guidance to States on the Medicaid coverage requirements for such services that includes best practices for ensuring children have access to comprehensive health care services, including children without a mental health or substance use disorder diagnosis.

''(2) REPORTS TO CONGRESS.—Not later than 6 months after each date on which the Secretary completes the activities described in paragraph (1), the Secretary shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the most recent activities completed for purposes of such paragraph that includes the findings made, and descriptions of actions taken by the Secretary or by States as a result of such activities, and any additional actions the Secretary plans to carry out or that States are required to carry out as a result of such activities.

''(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this subsection, to remain available until expended, $5,000,000, for each of fiscal years 2023 and 2024, and $1,000,000 for each fiscal year thereafter.

''(b) GAO STUDY AND REPORT.—

''(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the 'Comptroller General') shall conduct a study evaluating State implementation under Medicaid of the early and periodic screening, diagnostic, and treatment services benefit required for children by section 1905(a)(4)(B) of the Social Security Act (42 U.S.C. 1396d(a)(4)(B)) and as defined in section 1905(r) of such Act (42 U.S.C. 1396d(r)) and provided in accordance with the requirements of section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)), specifically with respect to State oversight of managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers, and shall provide recommendations as appropriate to improve State compliance with the requirements for providing such benefit, State oversight of managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers, and oversight of State programs under Medicaid by the Administrator of the Centers for Medicare & Medicaid Services.

''(2) REPORT.—Not later than 3 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) that includes the recommendations required by such paragraph, as well as recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

''(c) DEFINITIONS.—In this section:

''(1) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(2) SECRETARY.—Except as otherwise provided, the term 'Secretary' means the Secretary of Health and Human Services.

''(3) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act [42 U.S.C. 1396 et seq., 1397aa et seq.].''

ADDITIONAL SUPPORT FOR MEDICAID HOME AND COMMUNITY-BASED SERVICES DURING THE COVID–19 EMERGENCY

Pub. L. 117–2, title IX, § 9817, Mar. 11, 2021, 135 Stat. 216, provided that:

''(a) INCREASED FMAP.—

''(1) IN GENERAL.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) or section 1905(ff), in the case of a State that meets the HCBS program requirements under subsection (b), the Federal medical assistance percentage determined for the State under section 1905(b) of such Act (or, if applicable, under section 1905(ff)) and, if applicable, increased under subsection (y), (z), (aa), or (ii) of section 1905 of such Act (42 U.S.C. 1396d), section 1915(k) of such Act (42 U.S.C. 1396n(k)), or section 6008(a) of the Families First Coronavirus Response

Act (Public Law 116–127) [set out as a note below], shall be increased by 10 percentage points with respect to expenditures of the State under the State Medicaid program for home and community-based services (as defined in paragraph (2)(B)) that are provided during the HCBS program improvement period (as defined in paragraph (2)(A)). In no case may the application of the previous sentence result in the Federal medical assistance percentage determined for a State being more than 95 percent with respect to such expenditures. Any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance that are subject to the Federal medical assistance percentage increase specified under the first sentence of this paragraph shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

''(2) DEFINITIONS.—In this section:

''(A) HCBS PROGRAM IMPROVEMENT PERIOD.—The term 'HCBS program improvement period' means, with respect to a State, the period—

''(i) beginning on April 1, 2021; and

''(ii) ending on March 31, 2022.

''(B) HOME AND COMMUNITY-BASED SERVICES.—The term 'home and community-based services' means any of the following:

''(i) Home health care services authorized under paragraph (7) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

''(ii) Personal care services authorized under paragraph (24) of such section.

''(iii) PACE services authorized under paragraph (26) of such section.

''(iv) Home and community-based services authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of such Act (42 U.S.C. 1396n), such services authorized under a waiver under section 1115 of such Act (42 U.S.C. 1315), and such services through coverage authorized under section 1937 of such Act (42 U.S.C. 1396u–7).

''(v) Case management services authorized under section 1905(a)(19) of the Social Security Act (42 U.S.C. 1396d(a)(19)) and section 1915(g) of such Act (42 U.S.C. 1396n(g)).

''(vi) Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of such Act (42 U.S.C. 1396d(a)(13)).

''(vii) Such other services specified by the Secretary of Health and Human Services.

''(C) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is eligible for and enrolled for medical assistance under a State Medicaid program and includes an individual who becomes eligible for medical assistance under a State Medicaid program when removed from a waiting list.

''(D) MEDICAID PROGRAM.—The term 'Medicaid program' means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

''(E) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(b) STATE REQUIREMENTS FOR FMAP INCREASE.—As conditions for receipt of the increase under subsection (a) to the Federal medical assistance percentage determined for a State, the State shall meet each of the following requirements (referred to in subsection (a) as the HCBS program requirements):

''(1) SUPPLEMENT, NOT SUPPLANT.—The State shall use the Federal funds attributable to the increase under subsection (a) to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021.

''(2) REQUIRED IMPLEMENTATION OF CERTAIN ACTIVITIES.—The State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program.''

TEMPORARY INCREASE OF MEDICAID FMAP

Pub. L. 116–127, div. F, § 6008(a), (b), (d)–(g), Mar. 18, 2020, 134 Stat. 208, as amended by Pub. L. 116–136, div. A, title III, § 3720, Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–260, div. X, § 11, Dec. 27, 2020, 134 Stat. 2417; Pub. L. 117–328, div. FF, title V, § 5131(a), Dec. 29, 2022, 136 Stat. 5949, provided that:

''(a) IN GENERAL.—

''(1) TEMPORARY FMAP INCREASE.—Subject to subsections (b) and (f), for each calendar quarter occurring during the period beginning on the first day of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) and ending on December 31, 2023, the Federal medical assistance percentage determined for each State, including the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands, under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall be increased by the applicable number of percentage points for the quarter (as determined in paragraph (2)).

''(2) APPLICABLE NUMBER OF PERCENTAGE POINTS.—For purposes of paragraph (1), the applicable number of percentage points for a calendar quarter is the following:

''(A) For each calendar quarter that occurs during the portion of the period described in paragraph (1) that ends on March 31, 2023, 6.2 percentage points.

''(B) For the calendar quarter that begins on April 1, 2023, and ends on June 30, 2023, 5 percentage points.

''(C) For the calendar quarter that begins on July 1, 2023, and ends on September 30, 2023, 2.5 percentage points.

''(D) For the calendar quarter that begins on October 1, 2023, and ends on December 31, 2023, 1.5 percentage points.

''(b) REQUIREMENT FOR ALL STATES.—A State described in subsection (a)(1) may not receive the increase described in such subsection in the Federal medical assistance percentage for such State, with respect to a quarter, if—

''(1) eligibility standards, methodologies, or procedures under the State plan of such State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver under such title or section 1115 of such Act (42 U.S.C. 1315)) are more restrictive during such quarter than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on January 1, 2020;

''(2) the amount of any premium imposed by the State pursuant to section 1916 or 1916A of such Act (42 U.S.C. 1396*o*, 1396*o*–1) during such quarter exceeds the amount of such premium as of January 1, 2020;

''(3) the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of March 18, 2020, or enrolls for benefits under such plan (or waiver) during the period beginning on March 18, 2020, and ending March 31, 2023, shall be treated as eligible for such benefits through March 31, 2023, unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State; or

''(4) the State does not provide coverage under such plan (or waiver), without the imposition of cost sharing, during such quarter for any testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies.

''(d) DELAY IN APPLICATION OF PREMIUM REQUIREMENT.—During the 30 day period beginning on the date of enactment of this Act, a State shall not be ineligible for the increase to the Federal medical assistance per-

centage of the State described in subsection (a) on the basis that the State imposes a premium that violates the requirement of subsection (b)(2) if such premium was in effect on the date of enactment of this Act.

''(e) APPLICATION TO TITLE IV-E PAYMENTS.—If the District of Columbia receives the increase described in subsection (a) in the Federal medical assistance percentage for the District of Columbia with respect to a quarter, the Federal medical assistance percentage for the District of Columbia, as so increased, shall apply to payments made to the District of Columbia under part E of title IV of the Social Security Act (42 U.S.C. 670 et seq.) for that quarter, and the payments under such part shall be deemed to be made on the basis of the Federal medical assistance percentage applied with respect to such District for purposes of title XIX of such Act (42 U.S.C. 1396 et seq.) and as increased under subsection (a).

''(f) ELIGIBILITY REDETERMINATIONS DURING TRANSITION PERIOD.—

''(1) IN GENERAL.— For each calendar quarter occurring during the portion of the period described in subsection (a)(1) that begins on April 1, 2023, and ends on December 31, 2023 (such portion to be referred to in this subsection as the 'transition period'), if a State described in such subsection satisfies the conditions of subsection (b) and paragraph (2) of this subsection, the State shall receive the increase to the Federal medical assistance percentage of the State applicable under subsection (a). Nothing in this subsection shall be construed as prohibiting a State, following the expiration of the condition described in paragraph (3) of subsection (b), from initiating renewals, post-enrollment verifications, and redeterminations over a 12-month period for all individuals who are enrolled in such plan (or waiver) as of April 1, 2023.

''(2) CONDITIONS FOR FMAP INCREASE DURING TRANSITION PERIOD.—The conditions of this paragraph with respect to a State and the transition period are the following:

''(A) COMPLIANCE WITH FEDERAL REQUIREMENTS.—The State conducts eligibility redeterminations under title XIX of the Social Security Act in accordance with all Federal requirements applicable to such redeterminations, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act (42 U.S.C. 1396a(e)(14)(A)) or other alternative processes and procedures approved by the Secretary of Health and Human Services.

''(B) MAINTENANCE OF UP-TO-DATE CONTACT INFORMATION.—The State, using the National Change of Address Database Maintained by the United States Postal Service, State health and human services agencies, or other reliable sources of contact information, attempts to ensure that it has up-to-date contact information (including a mailing address, phone number, and email address) for each individual for whom the State conducts an eligibility redetermination.

''(C) REQUIREMENT TO ATTEMPT TO CONTACT BENEFICIARIES PRIOR TO DISENROLLMENT.—The State does not disenroll from the State plan or waiver any individual who is determined ineligible for medical assistance under the State plan or waiver pursuant to such a redetermination on the basis of returned mail unless the State first undertakes a good faith effort to contact the individual using more than one modality.

''(g) APPLICABLE QUARTERS.—A State that ceases to meet the requirements of subsection (b) or (f) (as applicable) shall not qualify for the increase described in subsection (a) in the Federal medical assistance percentage for such State for the calendar quarter in which the State ceases to meet such requirements.''

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 for a temporary increase of the Federal medical assistance percentage rate that States are reimbursed for most Medicaid expenditures through June 30, 2011.

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 assessment 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.''

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 [42 U.S.C. 1396 et seq.], 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 adjustment 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 [42 U.S.C. 1396 et seq., 1397aa et seq.], 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.''

Pub. L. 105–33, title IV, §4725(a), Aug. 5, 1997, 111 Stat. 518, 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 [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] 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

Pub. L. 105–33, title IV, §4744, Aug. 5, 1997, 111 Stat. 524, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with Governors, directors 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 [42 U.S.C. 1396 et seq.] 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

Pub. L. 101–508, title IV, §4706, Nov. 5, 1990, 104 Stat. 1388–173, 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 sec-

tion 1905(h) of the Social Security Act [42 U.S.C. 1396d(h)], and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act [42 U.S.C. 301 et seq.] 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 [42 U.S.C. 1396 et seq.] 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

Pub. L. 100–360, title IV, § 411(*l*)(3)(C)(i), formerly § 411(*l*)(3)(C), July 1, 1988, 102 Stat. 803, 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 [42 U.S.C. 1396r(c), see Effective Date note set out under 42 U.S.C. 1396r], section 1905(c) of the Social Security Act [42 U.S.C. 1396d(c)] 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

Pub. L. 99–272, title IX, § 9514, Apr. 7, 1986, 100 Stat. 213, 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 [42 U.S.C. 1396 et seq.] within 60 days after the date of the enactment of this Act [Apr. 7, 1986].''

LIFE SAFETY CODE RECOGNITION

Pub. L. 99–272, title IX, § 9515, Apr. 7, 1986, 100 Stat. 213, provided that: ''For purposes of section 1905(c) of the Social Security Act [42 U.S.C. 1396d(c)], 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

Pub. L. 97–35, title XXI, § 2165, Aug. 13, 1981, 95 Stat. 806, 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

Pub. L. 95–292, § 8(c), (d)(2), June 13, 1978, 92 Stat. 316, 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), 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));

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this subchapter and subject to subsection (b)(2), 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)), 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 1396*o* 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), 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), 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 by such a plan pursuant to title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], section 4980B of the Internal Revenue Code of 1986, or title VI[1] of the Employee Retirement Income Security Act of 1974.

(2) The term ''cost-effective'' has the meaning given that term in section 1397ee(c)(3)(A) of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1906, as added Pub. L. 101–508, title IV, § 4402(a)(2), Nov. 5, 1990, 104 Stat. 1388–161; amended Pub. L. 105–33, title IV, § 4741(b), Aug. 5, 1997, 111 Stat. 523; Pub. L. 111–148, title X, § 10203(b)(1), Mar. 23, 2010, 124 Stat. 927.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (e)(1), is classified generally to Title 26, Internal Revenue Code.

The Public Health Service Act, referred to in subsec. (e)(1), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXII of the Act is classified generally to subchapter XX (§ 300bb–1 et seq.) of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (e)(1), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829. Title VI of the Act probably means part 6 of subtitle B of title I of the Act which is classified generally to part 6 (§ 1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor, because the Act has no title VI. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

PRIOR PROVISIONS

A prior section 1396e, act Aug. 14, 1935, ch. 531, title XIX, § 1906, as added Jan. 2, 1968, Pub. L. 90–248, title II, § 226, 81 Stat. 903, created Advisory Council on Medical Assistance, set forth composition of Council, term of membership of members, and purposes of Council, and provided for compensation of members, prior to repeal by Pub. L. 92–603, title II, § 287, Oct. 30, 1972, 86 Stat. 1457, effective on the first day of the third calendar month following Oct. 30, 1972.

AMENDMENTS

2010—Subsec. (e)(2). Pub. L. 111–148 substituted ''has the meaning given that term in section 1397ee(c)(3)(A) of this title.'' for ''means, as established by the Secretary, that the reduction in expenditures under this subchapter with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.''

1997—Subsec. (a). Pub. L. 105–33, § 4741(b)(1), in introductory provisions, substituted ''Each'' for ''For purposes of section 1396a(a)(25)(G) of this title and subject to subsection (d) of this section, each'' and, in pars. (1) and (2), substituted ''may'' for ''shall''.

Subsec. (d). Pub. L. 105–33, § 4741(b)(2), struck out subsec. (d) which read as follows:

''(1) 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 requirements of this section 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.

''(2) This section, and section 1396a(a)(25)(G) of this title, shall only apply to a State that is one of the 50 States or the District of Columbia.''

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title X, § 10203(b), Mar. 23, 2010, 124 Stat. 927, provided that the amendment made by section 10203(b)(1) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE

Section 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 an Effective Date of 1990 Amendment note under section 1396a of this title.

§ 1396e–1. Premium assistance

(a) In general

A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals who are entitled to medical assistance under this subchapter (and, in the case of an individual under age 19, to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section and the offering of such a subsidy is cost-effective, as defined for purposes of section 1397ee(c)(3)(A) of this title.

[1] See References in Text note below.

(b) Qualified employer-sponsored coverage

(1) In general

Subject to paragraph (2)),[1] in this paragraph, the term ''qualified employer-sponsored coverage'' means a group health plan or health insurance coverage offered through an employer—

(A) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;[2]

(B) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(2) Exception

Such term does not include coverage consisting of—

(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

(3) Treatment as third party liability

The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under section 1396a(a)(25) of this title.

(c) Premium assistance subsidy

In this section, the term ''premium assistance subsidy'' means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of section 1396b(a) of this title, to be a payment for medical assistance.

(d) Voluntary participation

(1) Employers

Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

(2) Beneficiaries

No subsidy shall be provided to an individual under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.

(3) Opt-out permitted for any month

A State shall establish a process for permitting an individual (or the parent of an individual) receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

(e) Requirement to pay premiums and cost-sharing and provide supplemental coverage

In the case of the participation of an individual (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage 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 1396*o* of this title or, if applicable, section 1396*o*–1 of this title). The fact that an individual (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section 1396a(a)(25) of this title provides that payments for such assistance shall first be made under such coverage.

(Aug. 14, 1935, ch. 531, title XIX, § 1906A, as added Pub. L. 111–3, title III, § 301(b), Feb. 4, 2009, 123 Stat. 61; amended Pub. L. 111–148, title II, § 2003(a), (b), title X, § 10203(b)(2), Mar. 23, 2010, 124 Stat. 282, 283, 927.)

Editorial Notes

REFERENCES IN TEXT

Section 2701 of the Public Health Service Act, referred to in subsec. (b)(1)(A), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(C), (2), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2010—Pub. L. 111–148, § 2003(b), struck out ''option for children'' after ''assistance'' in section catchline.

Subsec. (a). Pub. L. 111–148, § 10203(b)(2)(A), inserted ''and the offering of such a subsidy is cost-effective, as defined for purposes of section 1397ee(c)(3)(A) of this title'' before period at end.

Pub. L. 111–148, § 2003(a)(1)(B), (C), struck out ''under age 19'' after ''all individuals'' and inserted '', in the case of an individual under age 19,'' after ''(and''.

Pub. L. 111–148, § 2003(a)(1)(A), which directed substitution of ''shall'' for ''may elect to'', was not executed

[1] So in original. The second closing parenthesis probably should not appear.

[2] See References in Text note below.

because of Pub. L. 111–148, §10203(b)(2)(B), set out as a note under this section.

Subsec. (c). Pub. L. 111–148, §2003(a)(2), struck out ''under age 19'' after ''by the individual''.

Subsec. (d)(2). Pub. L. 111–148, §2003(a)(3)(A), struck out ''under age 19'' after ''to an individual'' and substituted ''A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.'' for ''State may not require, as a condition of an individual under age 19 (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, apply for enrollment in qualified employer-sponsored coverage under this section.''

Subsec. (d)(3). Pub. L. 111–148, §2003(a)(3)(B), substituted ''an individual (or the parent of an individual)'' for ''the parent of an individual under age 19''.

Subsec. (e). Pub. L. 111–148, §2003(a)(4), struck out ''under age 19'' after ''an individual'' in two places.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2003(c), Mar. 23, 2010, 124 Stat. 283, provided that: ''The amendments made by this section [amending this section] take effect on January 1, 2014.''

Pub. L. 111–148, title X, §10203(b), Mar. 23, 2010, 124 Stat. 927, provided that the amendment made by section 10203(b)(2)(A) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE

Section effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

EFFECT OF CERTAIN AMENDMENT BY PUB. L. 111–148

Pub. L. 111–148, title X, §10203(b)(2)(B), Mar. 23, 2010, 124 Stat. 927, provided that: ''This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act [amending this section] and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.''

§ 1396f. Observance of religious beliefs

Nothing in this subchapter shall be construed to require any State which has a plan approved under this subchapter to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

(Aug. 14, 1935, ch. 531, title XIX, §1907, as added Pub. L. 90–248, title II, §232, Jan. 2, 1968, 81 Stat. 905.)

§ 1396g. State programs for licensing of administrators of nursing homes

(a) Nature of State program

For purposes of section 1396a(a)(29) of this title, a ''State program for the licensing of administrators of nursing homes'' is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing by State agency or board representative of concerned professions and institutions

Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of this section.

(c) Functions and duties of State agency or board

It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d) Waiver of standards other than good character or suitability standards

No State shall be considered to have failed to comply with the provisions of section 1396a(a)(29) of this title because the agency or board of such State (established pursuant to

subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1396a(a)(29) of this title are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).

(e) "Nursing home" and "nursing home administrator" defined

As used in this section, the term—

(1) ''nursing home'' means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).[1]

(2) ''nursing home administrator'' means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

(Aug. 14, 1935, ch. 531, title XIX, § 1908, as added Pub. L. 90–248, title II, § 236(b), Jan. 2, 1968, 81 Stat. 908; amended Pub. L. 92–603, title II, §§ 268(b), 269, 274(b), Oct. 30, 1972, 86 Stat. 1451, 1452; Pub. L. 93–233, § 18(y)(3), Dec. 31, 1973, 87 Stat. 973; Pub. L. 104–193, title IX, § 913, Aug. 22, 1996, 110 Stat. 2354; Pub. L. 105–33, title IV, § 4454(b)(2), Aug. 5, 1997, 111 Stat. 431.)

REPEAL OF SECTION

Pub. L. 101–508, title IV, § 4801(e)(11), Nov. 5, 1990, 104 Stat. 1388–217, provided that, effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title, this section is repealed.

Editorial Notes

CODIFICATION

Another section 1908 of act Aug. 14, 1935, was renumbered section 1908A and is classified to section 1396g–1 of this title.

AMENDMENTS

1997—Subsec. (e)(1). Pub. L. 105–33 which directed substitution of ''a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).'' for ''a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts; and'' in ''Section 1908(e)(1) (42 U.S.C. 1396g–1(e)(1))'' of the Social Security Act, was executed by making the substitution in subsec. (e)(1) of this section to reflect the probable intent of Congress, because section 1396g–1 of this title, which is also section 1908 of the Social Security Act, does not have a subsec. (e).

1996—Subsec. (e)(1). Pub. L. 104–193, which directed substitution of ''The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.'' for ''The First Church of Christ, Scientist, Boston, Massachusetts'' in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g–1(e)(1)) could not be executed to this section or section 1396g–1 of this title, both of which are section 1908. Section 1396g–1 does not have a subsec. (e) and subsec. (e)(1) of this section does not contain the quoted language with the word ''the'' capitalized.

1973—Subsec. (d). Pub. L. 93–233 struck out second sentence reading substantially the same as the first sentence but containing the following additional text reading ''other than such standards as relate to good character or suitability if—

''(1) such waiver is for a period which ends after being in effect for two years or on June 30, 1972, whichever is earlier, and

''(2) there is provided in the State (during all of the period for which waiver is in effect), a program of training and instruction designed to enable all individuals with respect to whom any such waiver is granted, to attain the qualifications necessary in order to meet such standards'' and also ''calendar year'' instead of ''three calendar years'' and reference to ''subsection (c)(1) of this section'' instead of ''subsection (c) of this section''.

Subsec. (e). Pub. L. 93–233 redesignated subsec. (g) as (e), and repealed prior subsec. (e) relating to authorization of appropriations for fiscal years 1968 through 1972 and to limitation of grants.

Subsec. (f). Pub. L. 93–233 repealed subsec. (f) providing for creation of National Advisory Council on Nursing Home Administration and for its composition, appointment of members, the Chairman, representation of interests, functions and duties, compensation and travel expenses, technical assistance, availability of assistance and data, and termination date of Dec. 31, 1971.

Subsec. (g). Pub. L. 93–233, redesignated subsec. (g) as (e).

1972—Subsec. (d). Pub. L. 92–603, §§ 269, 274(b), inserted references to the grant of waivers to individuals who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1396a(a)(29) of this title are first met by the State, have served as nursing home administrators and substituted ''subsection (c)(1)'' for ''subsection (b)(1)''.

Subsec. (g)(1). Pub. L. 92–603, § 268(b), inserted '', but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts'' after ''Secretary''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–193, title IX, § 913, Aug. 22, 1996, 110 Stat. 2354, provided that the amendment made by that section is effective Jan. 1, 1997.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 268(b) of Pub. L. 92–603 effective Oct. 30, 1972, see section 268(c) of Pub. L. 92–603, set out as a note under section 1396a of this title.

EFFECTIVE DATE

Pub. L. 90–248, title II, § 236(c), Jan. 2, 1968, 81 Stat. 910, provided that: ''Except as otherwise specified in the text thereof, the amendments made by this section [enacting this section and amending section 1396a of this title] shall take effect on July 1, 1970.''

[1] So in original. The period probably should be ''; and''.

§ 1396g–1. Required laws relating to medical child support

(a) In general

The laws relating to medical child support, which a State is required to have in effect under section 1396a(a)(60) of this title, are as follows:

(1) A law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that—

(A) the child was born out of wedlock,

(B) the child is not claimed as a dependent on the parent's Federal income tax return, or

(C) the child does not reside with the parent or in the insurer's service area.

(2) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, a law that requires such insurer—

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this subchapter or part D of subchapter IV; and

(C) not to disenroll (or eliminate coverage of) such a child unless the insurer is provided satisfactory written evidence that—

(i) such court or administrative order is no longer in effect, or

(ii) the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.

(3) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State, a law that requires such employer—

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this subchapter or part D of subchapter IV; and

(C) not to disenroll (or eliminate coverage of) any such child unless—

(i) the employer is provided satisfactory written evidence that—

(I) such court or administrative order is no longer in effect, or

(II) the child is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment, or

(ii) the employer has eliminated family health coverage for all of its employees; and

(D) to withhold from such employee's compensation the employee's share (if any) of premiums for health coverage (except that the amount so withheld may not exceed the maximum amount permitted to be withheld under section 1673(b) of title 15), and to pay such share of premiums to the insurer, except that the Secretary may provide by regulation for appropriate circumstances under which an employer may withhold less than such employee's share of such premiums.

(4) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under this subchapter and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(5) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

(A) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

(B) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

(C) to make payment on claims submitted in accordance with subparagraph (B) directly to such custodial parent, the provider, or the State agency.

(6) A law that permits the State agency under this subchapter to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who—

(A) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under this subchapter,

(B) has received payment from a third party for the costs of such services to such child, but

(C) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services,

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this subchapter, but any claims for current or past-due child support shall take priority over any such claims for the costs of such services.

(b) "Insurer" defined

For purposes of this section, the term ''insurer'' includes a group health plan, as defined in section 1167(1) of title 29, a health maintenance organization, and an entity offering a service benefit plan.

(Aug. 14, 1935, ch. 531, title XIX, § 1908A, formerly § 1908, as added Pub. L. 103–66, title XIII, § 13623(b), Aug. 10, 1993, 107 Stat. 633, renumbered § 1908A, Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(y)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 103–66, title XIII, § 13623(c), Aug. 10, 1993, 107 Stat. 635, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1396a of this title] apply to calendar quarters beginning on or after April 1, 1994, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2) In the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, 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 these additional requirements 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 [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

§ 1396h. State false claims act requirements for increased State share of recoveries

(a) In general

Notwithstanding section 1396d(b) of this title, if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

(b) Requirements

For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31 with respect to any expenditure described in section 1396b(a) of this title.

(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31.

(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31.

(c) Deemed compliance

A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

(d) No preclusion of broader laws

Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, with respect to programs in addition to the State program under this subchapter, or with respect to expenditures in addition to expenditures described in section 1396b(a) of this title, from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.

(Aug. 14, 1935, ch. 531, title XIX, § 1909, as added Pub. L. 109–171, title VI, § 6031(a), Feb. 8, 2006, 120 Stat. 72.)

Editorial Notes

PRIOR PROVISIONS

A prior section 1396h, act Aug. 14, 1935, ch. 531, title XIX, § 1909, as added and amended Oct. 30, 1972, Pub. L. 92–603, title II, §§ 242(c), 278(b)(9), 86 Stat. 1419, 1454; Oct. 25, 1977, Pub. L. 95–142, § 4(b), 91 Stat. 1181; Dec. 5, 1980, Pub. L. 96–499, title IX, § 917, 94 Stat. 2625; Aug. 18, 1987, Pub. L. 100–93, § 4(a)–(c), 101 Stat. 688, 689, related to criminal penalties for acts involving Medicare and State health care programs, prior to being renumbered section 1128B of title XI of act Aug. 14, 1935, by section 4(d) of Pub. L. 100–93 and transferred to section 1320a–7b of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 109–171, title VI, § 6031(b), Feb. 8, 2006, 120 Stat. 73, as amended by Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: ''Except as provided in section 6034(e) [set out as an Effective Date of 2006 Amendment note under section 1396a of this title], the amendments made by this section [enacting this section] take effect on January 1, 2007.''

§ 1396i. Certification and approval of rural health clinics and intermediate care facilities for mentally retarded

(a)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under subchapter XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this subchapter.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

(b)(1) The Secretary may cancel approval of any intermediate care facility for the mentally retarded at any time if he finds on the basis of a determination made by him as provided in section 1396a(a)(33)(B) of this title that a facility fails to meet the requirements contained in section 1396a(a)(31) of this title or section 1396d(d) of this title, or if he finds grounds for termination of his agreement with the facility pursuant to section 1395cc(b) of this title. In that event the Secretary shall notify the State agency and the intermediate care facility for the mentally retarded that approval of eligibility of the facility to participate in the programs es-

tablished by this subchapter and subchapter XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any intermediate care facility for the mentally retarded which is dissatisfied with a determination by the Secretary that it no longer qualifies as a[1] intermediate care facility for the mentally retarded for purposes of this subchapter, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

(Aug. 14, 1935, ch. 531, title XIX, §1910, as added and amended Pub. L. 92–603, title II, §§249A(a), 278(b)(12), Oct. 30, 1972, 86 Stat. 1426, 1454; Pub. L. 95–210, §2(d), Dec. 13, 1977, 91 Stat. 1489; Pub. L. 96–499, title IX, §916(b)(2), Dec. 5, 1980, 94 Stat. 2624; Pub. L. 100–203, title IV, §4212(e)(3), Dec. 22, 1987, 101 Stat. 1330–213; Pub. L. 100–360, title IV, §411(*l*)(6)(F), July 1, 1988, as added Pub. L. 100–485, title VI, §608(d)(27)(J), Oct. 13, 1988, 102 Stat. 2423; Pub. L. 101–239, title VI, §6901(d)(5), Dec. 19, 1989, 103 Stat. 2301; Pub. L. 103–296, title I, §108(d)(4), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(n)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397.)

Editorial Notes

AMENDMENTS

1999—Pub. L. 106–113 struck out ''of'' after ''approval of'' in section catchline.

1994—Subsec. (b)(2). Pub. L. 103–296 inserted before period at end of first sentence '', except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively''.

1989—Pub. L. 101–239, §6901(d)(5)(A), substituted ''rural health clinics and intermediate care facilities for the mentally retarded'' for ''rural health clinics'' in section catchline.

Subsec. (b)(1). Pub. L. 101–239, §6901(d)(5)(B)–(D), substituted ''any intermediate care facility for the mentally retarded'' for ''any skilled nursing or intermediate care facility'', ''section 1396a(a)(31) of this title or section 1396d(d) of this title'' for ''section 1396a(a)(28) of this title or section 1396r of this title or section 1396d(c) of this title'', and ''the intermediate care facility for the mentally retarded'' for ''the skilled nursing facility or intermediate care facility''.

Subsec. (b)(2). Pub. L. 101–239, §6901(d)(5)(D), substituted ''intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility'' in two places.

1988—Subsec. (b)(1). Pub. L. 100–360, §411(*l*)(6)(F), as added by Pub. L. 100–485, §608(d)(27)(J), inserted ''or section 1396r of this title'' after ''1396a(a)(28) of this title''.

1987—Pub. L. 100–203 struck out ''skilled nursing facilities and'' before ''of rural'' in section catchline, redesignated subsecs. (b) and (c) as (a) and (b), respectively, and struck out former subsec. (a) which related to certification and approval of skilled nursing facilities.

1980—Subsec. (c). Pub. L. 96–499 added subsec. (c).

1977—Pub. L. 95–210 substituted ''facilities and of rural health clinics'' for ''facilities'' in section catchline, redesignated existing subsecs. (a) and (b) as (a)(1) and (2), respectively, and added subsec. (b).

Statutory Notes and Related Subsidiaries

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 1989 AMENDMENT

Amendment by Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 6901(d)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by 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.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by 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.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r 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 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 first day of 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

Section effective with respect to agreements filed with Secretary under section 1395cc of this title by

[1] So in original. Probably should be ''an''.

skilled nursing facilities before, on, or after Oct. 30, 1972, but accepted by him on or after such date, see section 249A(e) of Pub. L. 92–603, set out as an Effective Date of 1972 Amendment note under section 1395cc of this title.

§ 1396j. Indian Health Service facilities

(a) Eligibility for reimbursement for medical assistance

A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this subchapter.

(b) Facilities deemed to meet requirements upon submission of acceptable plan for achieving compliance

Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this subchapter which are applicable generally to such facility, but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

(c) Agreement to reimburse State agency for providing care and services

The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

(d) Cross reference

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see section 1645 of title 25.[1]

(Aug. 14, 1935, ch. 531, title XIX, § 1911, as added Pub. L. 94–437, title IV, § 402(a), Sept. 30, 1976, 90 Stat. 1409; amended Pub. L. 100–203, title IV, §§ 4118(f)(1), 4211(h)(8), Dec. 22, 1987, 101 Stat. 1330–155, 1330–206; Pub. L. 100–360, title IV, § 411(k)(10)(E), July 1, 1988, 102 Stat. 796; Pub. L. 106–417, § 3(b)(2), Nov. 1, 2000, 114 Stat. 1815.)

[1] See References in Text note below.

Editorial Notes

References in Text

Section 1645 of title 25, referred to in subsec. (d), was amended generally by Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935, and, as so amended, no longer contains provisions relating to direct billing of medicare, medicaid, and other third party payors.

Amendments

2000—Subsec. (d). Pub. L. 106–417 added subsec. (d).

1988—Subsecs. (a), (b). Pub. L. 100–360, § 411(k)(10)(E), made technical correction to directory language of Pub. L. 100–203, § 4118(f)(1)(A), see 1987 Amendment note below.

1987—Subsecs. (a), (b). Pub. L. 100–203, § 4118(f)(1)(A), as amended by Pub. L. 100–360, § 411(k)(10)(E), substituted '', nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan'' for ''or nursing facility''.

Pub. L. 100–203, § 4211(h)(8), substituted ''or nursing facility'' for '', intermediate care facility, or skilled nursing facility'' wherever appearing.

Subsec. (c). Pub. L. 100–203, § 4118(f)(1)(B), added subsec. (c).

Statutory Notes and Related Subsidiaries

Effective Date of 2000 Amendment

Amendment by Pub. L. 106–417 effective Oct. 1, 2000, see section 3(c) of Pub. L. 106–417, set out as a note under section 1645 of Title 25, Indians.

Effective Date of 1988 Amendment

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by 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.

Effective Date of 1987 Amendment

Pub. L. 100–203, title IV, § 4118(f)(2), Dec. 22, 1987, 101 Stat. 1330–156, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to health care services performed on or after the date of the enactment of this Act [Dec. 22, 1987].''

Amendment by section 4211(h)(8) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r 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.

Agreements To Reimburse State Agency for Health Care and Services Provided by Agency to Indians

Pub. L. 94–437, title IV, § 402(b), Sept. 30, 1976, 90 Stat. 1409, which authorized Secretary to enter into agreements to reimburse State agencies for health care and services provided in Service facilities to Indians eligible for medical assistance under this subchapter, was repealed by Pub. L. 100–713, title IV, § 401(b), Nov. 23, 1988, 102 Stat. 4818, applicable to services performed on or after the Nov. 23, 1988.

Payments Into Special Fund To Improve Indian Health Service Facilities To Achieve Compliance With Conditions and Requirements

Pub. L. 94–437, title IV, § 402(c), Sept. 30, 1976, 90 Stat. 1409, as amended by Pub. L. 100–713, title IV, § 401(a), Nov. 23, 1988, 102 Stat. 4818, provided that payments to which any Indian Health Service facility was entitled

by reason of this section were to be placed in a special fund of the Secretary for improvements of facilities of the Service to comply with requirements of this subchapter, required minimum funding for each service unit making collections for such facilities, and provided for section 402(c) of Pub. L. 94–437 to cease to apply when Secretary determined that substantially all such facilities complied with requirements of this subchapter, prior to the general amendment of section 402 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(b)(1), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(c) of Pub. L. 94–437, which is classified to section 1641(c) of Title 25, Indians.

MEDICAID PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Pub. L. 94–437, title IV, § 402(d), Sept. 30, 1976, 90 Stat. 1410, provided that any payments received for services provided recipients under this section were not to be considered in determining appropriations for the provision of health care and services to Indians, prior to the general amendment of section 402 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(b)(1), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(a) of Pub. L. 94–437, which is classified to section 1641(a) of Title 25, Indians.

§ 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(*l*)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

(Aug. 14, 1935, ch. 531, title XIX, § 1912, as added Pub. L. 95–142, § 11(b), Oct. 25, 1977, 91 Stat. 1196; amended Pub. L. 98–369, div. B, title III, § 2367(b), July 18, 1984, 98 Stat. 1109; Pub. L. 99–272, title IX, § 9503(e), Apr. 7, 1986, 100 Stat. 207; Pub. L. 101–508, title IV, § 4606(a), Nov. 5, 1990, 104 Stat. 1388–170; Pub. L. 113–67, div. A, title II, § 202(b)(2), Dec. 26, 2013, 127 Stat. 1177; Pub. L. 115–123, div. E, title XII, § 53102(b)(1), Feb. 9, 2018, 132 Stat. 298.)

Editorial Notes

AMENDMENTS

2018—Subsec. (a)(1)(A). Pub. L. 115–123, § 53102(b)(1), repealed Pub. L. 113–67, § 202(b)(2), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

2013—Subsec. (a)(1)(A). Pub. L. 113–67, § 202(b)(2), which directed substitution of ''any payment from a third party that has a legal liability to pay for care and services available under the plan'' for ''payment for medical care from any third party'', was repealed by Pub. L. 115–123, § 53102(b)(1).

1990—Subsec. (a)(1)(B). Pub. L. 101–508 inserted ''the individual is described in section 1396a(*l*)(1)(A) of this title or'' after ''unless (in either case)''.

1986—Subsec. (a)(1)(C). Pub. L. 99–272 added subpar. (C).

1984—Subsec. (a). Pub. L. 98–369 substituted ''State plan for medical assistance shall'' for ''State plan for medical assistance may''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title XII, § 53102(b)(1), Feb. 9, 2018, 132 Stat. 298, provided that the repeal of section 202(b) of Pub. L. 113–67 is effective Sept. 30, 2017, and the provisions amended by section 202(b) shall be applied and administered as if such amendments had never been enacted. In addition, such repeal by section

53102(b)(1) of Pub. L. 115–123 applicable with respect to any open claims, including claims pending, generated, or filed, after Sept. 30, 2017, see section 53102(b)(3) of Pub. L. 115–123, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4606(b), Nov. 5, 1990, 104 Stat. 1388–170, 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].''

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 applicable to calendar quarters beginning on or after Apr. 7, 1986, except as otherwise provided, see section 9503(g)(1), (2) of Pub. L. 99–272, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective Oct. 1, 1984, except as otherwise provided, see section 2367(c) of Pub. L. 98–369, set out as a note under section 1396a of this title.

§ 1396*l*. Hospital providers of nursing facility services

(a) Notwithstanding any other provision of this subchapter, payment may be made, in accordance with this section, under a State plan approved under this subchapter for nursing facility services furnished by a hospital which has in effect an agreement under section 1395tt of this title and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1396r of this title.

(b)(1) Except as provided in paragraph (3), payment to any such hospital, for any nursing facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to nursing facilities, respectively,[1] located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1395tt of this title, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including subchapter XVIII, this subchapter, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

(3) Payment to all such hospitals, for any nursing facility services furnished pursuant to subsection (a), may be made at a payment rate established by the State in accordance with the requirements of section 1396a(a)(13)(A) of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1913, as added Pub. L. 96–499, title IX, § 904(b), Dec. 5, 1980, 94 Stat. 2617; amended Pub. L. 98–369, div. B, title III, § 2369(a), July 18, 1984, 98 Stat. 1110; Pub. L. 100–203, title IV, § 4211(h)(9), Dec. 22, 1987, 101 Stat. 1330–206.)

[1] So in original, '', respectively,'' probably should not appear.

Editorial Notes

AMENDMENTS

1987—Pub. L. 100–203, § 4211(h)(9)(A), substituted ''nursing facility services'' for ''skilled nursing and intermediate care services'' in section catchline.

Subsec. (a). Pub. L. 100–203, § 4211(h)(9)(B), substituted ''nursing facility services'' for ''skilled nursing facility services and intermediate care facility services'' and inserted ''and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1396r of this title'' before period at end.

Subsec. (b)(1). Pub. L. 100–203, § 4211(h)(9)(C), substituted ''nursing facility services'' for ''skilled nursing or intermediate care facility services'' and ''nursing facilities'' for ''skilled nursing and intermediate care facilities''.

Subsec. (b)(3). Pub. L. 100–203, § 4211(h)(9)(D), substituted ''nursing facility services'' for ''skilled nursing or intermediate care facility services''.

1984—Subsec. (b)(1). Pub. L. 98–369, § 2369(a)(1), substituted ''Except as provided in paragraph (3), payment'' for ''Payment''.

Subsec. (b)(3). Pub. L. 98–369, § 2369(a)(2), added par. (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r 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 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2369(b), July 18, 1984, 98 Stat. 1110, provided that: ''The amendments made by this section [amending this section] shall apply to payments for services furnished after the date of the enactment of this Act [July 18, 1984].''

EFFECTIVE DATE

Section effective on date on which final regulations to implement the section are first issued, see section 904(d) of Pub. L. 96–499, set out as an Effective Date note under section 1395tt of this title.

§ 1396m. Withholding of Federal share of payments for certain medicare providers

(a) Adjustment of Federal matching payments

The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1395cc of this title; and (B)(i) from which the Secretary has been unable to recover overpayments made under subchapter XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under subchapter XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1395u(b)(3)(B)(ii) of this title, and (ii) during the annual period immediately preceding such quarter submitted no claims

for payment under subchapter XVIII, or submitted claims for payment under subchapter XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under subchapter XVIII.

(b) Reductions in payments to and by States

The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this subchapter for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under subchapter XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) Notice

The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) Regulations

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under subchapter XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XVIII and to which the institution or person would otherwise be entitled under this subchapter.

(e) Restoration to trust funds of recovered amounts

The Secretary shall restore to the trust funds established under sections 1395i and 1395t of this title, as appropriate, amounts recovered under this section as setoffs against overpayments under subchapter XVIII.

(f) Liability of States for withheld payments

Notwithstanding any other provision of this subchapter, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this subchapter which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

(Aug. 14, 1935, ch. 531, title XIX, §1914, as added Pub. L. 96–499, title IX, §905(d), Dec. 5, 1980, 94 Stat. 2618.)

§ 1396n. Compliance with State plan and payment provisions

(a) Activities deemed as compliance

A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1396a(a) of this title solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1396d(a)(3) of this title or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) of section 1395x(s) of this title, and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this subchapter or under part A or part B of subchapter XVIII; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) Waivers to promote cost-effectiveness and efficiency

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this subchapter)

can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this subchapter) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section 1396r–4 of this title and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A) of this title.

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title. Subsection (h)(2) shall apply to a waiver under this subsection.

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as ''medical assistance'' under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term ''room and board'' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of in-

come of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term ''habilitation services''—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as such terms are defined in section 1401 of title 20) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 730 of title 29.

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under subchapter V in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d) Home and community-based services for elderly

(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as ''medical assistance'' under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the

individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term ''room and board'' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1396b of this title to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this subchapter for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this subchapter for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning

of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the ''lesser of 7 percent'' shall be deemed to be a reference to the ''greater of 7 percent''.

(iv) If there is enacted after December 22, 1987, an Act which amends this subchapter whose provisions become effective on or after such date and which results in an increase in the aggregate amount of medical assistance under this subchapter for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term ''home and community-based services'' includes services described in sections 1396d(a)(7) and 1396d(a)(8) of this title, services described in subsection (c)(4)(B), services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term ''base year'' means the most recent year (ending before December 22, 1987) for which actual final expenditures under this subchapter have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before December 22, 1987, the term ''base year'' means fiscal year 1989.

(iii) The term ''intermediate care facility services'' does not include services furnished in an institution certified in accordance with section 1396d(d) of this title.

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1316(b) of this title.

(B) Notwithstanding any other provision of this chapter, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e) Waiver for children infected with AIDS or drug dependent at birth

(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as ''medical assistance'' under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of subchapter IV.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure

that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).

(f) Monitor of implementation of waivers; termination of waiver for noncompliance; time limitation for action on requests for plan approval, amendments, or waivers

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g) Optional targeted case management services

(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1396a(a)(1) of this title and section 1396a(a)(10)(B) of this title. The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1396a(a)(23) of this title. A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in section 1396a(z)(1)(A) of this title and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection:

(A)(i) The term ''case management services'' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(ii) Such term includes the following:

(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

(aa) Taking client history.

(bb) Identifying the needs of the individual, and completing related documentation.

(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

(aa) whether services are being furnished in accordance with an individual's care plan;

(bb) whether the services in the care plan are adequate; and

(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

(iii) Such term does not include the direct delivery of an underlying medical, edu-

cational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

(I) Research gathering and completion of documentation required by the foster care program.

(II) Assessing adoption placements.

(III) Recruiting or interviewing potential foster care parents.

(IV) Serving legal papers.

(V) Home investigations.

(VI) Providing transportation.

(VII) Administering foster care subsidies.

(VIII) Making placement arrangements.

(B) The term ''targeted case management services'' are case management services that are furnished without regard to the requirements of section 1396a(a)(1) of this title and section 1396a(a)(10)(B) of this title to specific classes of individuals or to individuals who reside in specified areas.

(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

(4)(A) In accordance with section 1396a(a)(25) of this title, Federal financial participation only is available under this subchapter for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A–87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act [42 U.S.C. 300ff et seq.] or by the Indian Health Service.

(h) Period of waivers; continuations

(1) No waiver under this section (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiver under section 1315 of this title, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this subchapter, to extend the waiver.

(B) In this paragraph, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and is eligible for medical assistance under the State plan under this subchapter or under a waiver of such plan.

(i) State plan amendment option to provide home and community-based services for elderly and disabled individuals

(1) In general

Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1397jj(c)(5) of this title), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) Needs-based criteria for eligibility for, and receipt of, home and community-based services

The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) Establishment of more stringent needs-based eligibility criteria for institutionalized care

The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hos-

pital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

(C) Projection of number of individuals to be provided home and community-based services

The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

(D) Criteria based on individual assessment

(i) In general

The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) Adjustment authority

The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) Independent evaluation and assessment

(i) Eligibility determination

The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) Assessment

In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

(II) prevent the provision of unnecessary or inappropriate care; and

(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) Assessment

The independent assessment required under subparagraph (E)(ii) shall include the following:

(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) Individualized care plan

(i) In general

In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) Plan requirements

The State ensures that the individualized care plan for an individual—

(I) is developed—

(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and,

where appropriate the individual's family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

(iii) State option to offer election for self-directed services

(I) Individual choice

At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

(II) Self-directed services

The term ''self-directed'' means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) Assessment

There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) Service plan

Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) Plan requirements

For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(IV) Budget process

With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) Quality assurance; conflict of interest standards

(i) Quality assurance

The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) Conflict of interest standards

The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) Redeterminations and appeals

The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) Presumptive eligibility for assessment

The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to be-

lieve may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

(2) Definition of individual's representative

In this section, the term ''individual's representative'' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) Nonapplication

A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1396a(a)(10)(B) of this title (relating to comparability) and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

(4) No effect on other waiver authority

Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1315 of this title.

(5) Continuation of Federal financial participation for medical assistance provided to individuals as of effective date of State plan amendment

Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1315 of this title that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.

(6) State option to provide home and community-based services to individuals eligible for services under a waiver

(A) In general

A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1315 of this title to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title.

(B) Application of same requirements for individuals satisfying needs-based criteria

Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

(C) Authority to offer different type, amount, duration, or scope of home and community-based services

A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

(7) State option to offer home and community-based services to specific, targeted populations

(A) In general

A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

(B) 5-year term

(i) In general

An election by a State under this paragraph shall be for a period of 5 years.

(ii) Phase-in of services and eligibility permitted during initial 5-year period

A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are pro-

vided, before the end of the initial 5-year period.

(C) Renewal

An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning[1] of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.

(j) Optional choice of self-directed personal assistance services

(1) A State may provide, as ''medical assistance'', payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

(B) The State will provide, with respect to individuals who—

(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

(ii) may require self-directed personal assistance services; and

(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1396a(a)(1) of this title and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1396a(a)(10)(B) of this title.

(4)(A) For purposes of this subsection, the term ''self-directed personal assistance services'' means personal care and related services, or home and community-based services otherwise available under the plan under this subchapter or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

(B) At the election of the State—

(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(5) For purpose of this section, the term ''approved self-directed services plan and budget'' means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

(A) Self-direction

The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

(B) Assessment of needs

There is an assessment of the needs, strengths, and preferences of the participants for such services.

(C) Service plan

A plan for such services (and supports for such services) for the participant has been

[1] So in original. Probably should be preceded by ''the''.

developed and approved by the State based on such assessment through a person-centered process that—

(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

(D) Service budget

A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

(E) Application of quality assurance and risk management

There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1396b(a) of this title.

(k) State plan option to provide home and community-based attendant services and supports

(1) In general

Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

(A) Availability

The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

(iv) the furnishing of which—

(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

(B) Included services and supports

In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

(iii) voluntary training on how to select, manage, and dismiss attendants.

(C) Excluded services and supports

Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

(i) room and board costs for the individual;

(ii) special education and related services provided under the Individuals with Disabilities Education Act [20 U.S.C. 1400 et seq.] and vocational rehabilitation services provided under the Rehabilitation Act of 1973 [29 U.S.C. 701 et seq.];

(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

(iv) medical supplies and equipment; or

(v) home modifications.

(D) Permissible services and supports

The home and community-based attendant services and supports may include—

(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(2) Increased Federal financial participation

For purposes of payments to a State under section 1396b(a)(1) of this title, with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1396d(b) of this title) shall be increased by 6 percentage points.

(3) State requirements

In order for a State plan amendment to be approved under this subsection, the State shall—

(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1396d(a) of this title, this section, section 1315 of this title, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(4) Compliance with certain laws

A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 [29 U.S.C. 201 et seq.] and applicable Federal and State laws regarding—

(A) withholding and payment of Federal and State income and payroll taxes;

(B) the provision of unemployment and workers compensation insurance;

(C) maintenance of general liability insurance; and

(D) occupational health and safety.

(5) Evaluation, data collection, and report to Congress

(A) Evaluation

The Secretary shall conduct an evaluation of the provision of home and community-

based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an[2] comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

(B) Data collection

The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

(C) Reports

Not later than—

(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(6) Definitions

In this subsection:

(A) Activities of daily living

The term ''activities of daily living'' includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(B) Consumer controlled

The term ''consumer controlled'' means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

(C) Delivery models

(i) Agency-provider model

The term ''agency-provider model'' means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

(ii) Other models

The term ''other models'' means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

(D) Health-related tasks

The term ''health-related tasks'' means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

(E) Individual's representative

The term ''individual's representative'' means a parent, family member, guardian, advocate, or other authorized representative of an individual[3]

(F) Instrumental activities of daily living

The term ''instrumental activities of daily living'' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

***(l)* State plan amendment option to provide medical assistance for certain individuals who are patients in certain institutions for mental diseases**

(1) In general

With respect to calendar quarters beginning on or after October 1, 2019, a State may elect, through a State plan amendment, to provide medical assistance for items and services furnished to an eligible individual who is a patient in an eligible institution for mental diseases in accordance with the requirements of this subsection.

(2) Payments

Subject to paragraphs (3) and (4), amounts expended under a State plan amendment under paragraph (1) for services described in such paragraph furnished, with respect to a 12-month period, to an eligible individual who is a patient in an eligible institution for mental diseases shall be treated as medical assistance for which payment is made under section 1396b(a) of this title but only to the extent that such services are furnished for not more than a period of 30 days (whether or not consecutive) during such 12-month period.

[2] So in original. Probably should be ''a''.

[3] So in original. Probably should be followed by a period.

(3) Maintenance of effort

(A) In general

As a condition for a State receiving payments under section 1396b(a) of this title for medical assistance provided in accordance with this subsection, the State shall (during the period in which it so furnished such medical assistance through a State plan amendment under this subsection) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) from non-Federal funds for items and services (including services described in subparagraph (B)) furnished to eligible individuals in outpatient and community-based settings that is not less than the level of such funding for such items and services for, at the option of the State—

(i) fiscal year 2018; or

(ii) the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection.

(B) Services described

For purposes of subparagraph (A), services described in this subparagraph are the following:

(i) Outpatient and community-based substance use disorder treatment.

(ii) Evidence-based recovery and support services.

(iii) Clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies.

(iv) Outpatient medication-assisted treatment, related therapies, and pharmacology.

(v) Counseling and clinical monitoring.

(vi) Outpatient withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs.

(vii) Routine monitoring of medication adherence.

(viii) Other outpatient and community-based services for the treatment of substance use disorders, as designated by the Secretary.

(C) State reporting requirement

(i) In general

Prior to approval of a State plan amendment under this subsection, as a condition for a State receiving payments under section 1396b(a) of this title for medical assistance provided in accordance with this subsection, the State shall report to the Secretary, in accordance with the process established by the Secretary under clause (ii), the information deemed necessary by the Secretary under such clause.

(ii) Process

Not later than the date that is 8 months after October 24, 2018, the Secretary shall establish a process for States to report to the Secretary, at such time and in such manner as the Secretary deems appropriate, such information as the Secretary deems necessary to verify a State's compliance with subparagraph (A).

(D) Application of maintenance of effort requirements to certain States

In the case of a State with a State plan amendment in effect on September 30, 2023, for the 1-year period beginning on March 9, 2024, the provisions of subparagraph (A) shall be applied as if the amendments to such subparagraph made by the Consolidated Appropriations Act, 2024 had never been made.

(4) Ensuring a continuum of services

(A) In general

As a condition for a State receiving payments under section 1396b(a) of this title for medical assistance provided in accordance with this subsection, the State shall carry out each of the requirements described in subparagraphs (B) through (F).

(B) Notification

The State shall have in place evidence-based, substance use disorder-specific individual placement criteria and utilization management approaches to ensure placement of eligible individuals in an appropriate level of care, including criteria and approaches to ensure that eligible individuals receive appropriate evidence-based clinical screening prior to being furnished with items and services in an eligible institution for mental diseases, including initial and periodic assessments to determine the appropriate level of care, length of stay, and setting for such care for each individual. The State shall notify the Secretary at such time and in such form and manner as the Secretary shall require of such criteria and utilization management approaches.

(C) Outpatient services; inpatient and residential services

(i) Outpatient services

The State shall, at a minimum, provide medical assistance for services that could otherwise be covered under the State plan, consistent with each of the following outpatient levels of care:

(I) Early intervention for individuals who, for a known reason, are at risk of developing substance-related problems and for individuals for whom there is not yet sufficient information to document a diagnosable substance use disorder.

(II) Outpatient services for less than 9 hours per week for adults, and for less than 6 hours per week for adolescents, for recovery or motivational enhancement therapies and strategies.

(III) Intensive outpatient services for 9 hours or more per week for adults, and for 6 hours or more per week for adolescents, to treat multidimensional instability.

(IV) Partial hospitalization services for 20 hours or more per week for adults and adolescents to treat multidimen-

sional instability that does not require 24-hour care.

(ii) Inpatient and residential services

The State shall provide medical assistance for services that could otherwise be covered under the State plan, consistent with at least 2 of the following inpatient and residential levels of care:

(I) Clinically managed, low-intensity residential services that provide adults and adolescents with 24-hour living support and structure with trained personnel and at least 5 hours of clinical service per week per individual.

(II) Clinically managed, population-specific, high-intensity residential services that provide adults with 24-hour care with trained counselors to stabilize multidimensional imminent danger along with less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.

(III) Clinically managed, medium-intensity residential services for adolescents, and clinically managed, high-intensity residential services for adults, that provide 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment.

(IV) Medically monitored, high-intensity inpatient services for adolescents, and medically monitored, intensive inpatient services withdrawal management for adults, that provide 24-hour nursing care, make physicians available for significant conditions, and provide counseling services 16 hours per day.

(V) Medically managed, intensive inpatient services for adolescents and adults that provide 24-hour nursing care and daily physician care for severe, unstable conditions.

(D) Transition of care

In order to ensure an appropriate transition for an eligible individual from receiving care in an eligible institution for mental diseases to receiving care at a lower level of clinical intensity within the continuum of care (including outpatient services), the State shall ensure that—

(i) a placement in such eligible institution for mental diseases would allow for an eligible individual's successful transition to the community, considering such factors as proximity to an individual's support network (such as family members, employment, and counseling and other services near an individual's residence); and

(ii) all eligible institutions for mental diseases that furnish items and services to individuals for which medical assistance is provided under the State plan—

(I) are able to provide care at such lower level of clinical intensity; or

(II) have an established relationship with another facility or provider that is able to provide care at such lower level of clinical intensity and accepts patients receiving medical assistance under this subchapter under which the eligible institution for mental diseases may arrange for individuals to receive such care from such other facility or provider.

(E) Review process

The State shall, using nationally recognized substance use disorder-specific program standards, have in place a process to review the compliance of eligible institutions for mental diseases with such program standards specified by the State.

(F) Assessment

(i) In general

The State shall, not later than 12 months after the approval of a State plan amendment described in this subsection (or, in the case of a State that has such an amendment approved as of September 30, 2023, not later than 12 months after March 9, 2024), commence an assessment of—

(I) the availability of treatment for individuals enrolled under a State plan under this subchapter (or waiver of such plan) in each level of care described in subparagraph (C), including how such availability varies by region of the State; and

(II) the availability of medication-assisted treatment and medically supervised withdrawal management services for such individuals, including how such availability varies by region of the State.

(ii) Required completion

The State shall complete an assessment described in clause (i) not later than 12 months after the date the State commences such assessment.

(5) Application to managed care

Payments for, and limitations to, medical assistance furnished in accordance with this subsection shall be in addition to and shall not be construed to limit or supersede the ability of States to make monthly capitation payments to managed care organizations for individuals receiving treatment in institutions for mental diseases in accordance with section 438.6(e) of title 42, Code of Federal Regulations (or any successor regulation).

(6) Other medical assistance

The provision of medical assistance for items and services furnished to an eligible individual who is a patient in an eligible institution for mental diseases in accordance with the requirements of this subsection shall not prohibit Federal financial participation for medical assistance for items or services that are provided to such eligible individual in or away from the eligible institution for mental disease during any period in which the eligible individual is receiving items or services in accordance with this subsection.

(7) Definitions

In this subsection:

(A) Eligible individual

The term ''eligible individual'' means an individual who—

(i) with respect to a State, is enrolled for medical assistance under the State plan or a waiver of such plan;

(ii) is at least 21 years of age;

(iii) has not attained 65 years of age; and

(iv) has at least 1 substance use disorder.

(B) Eligible institution for mental diseases

The term ''eligible institution for mental diseases'' means an institution for mental diseases that—

(i) follows reliable, evidence-based practices; and

(ii) offers at least 2 forms of medication-assisted treatment for substance use disorders on site, including, in the case of medication-assisted treatment for opioid use disorder, at least 1 antagonist and 1 partial agonist.

(C) Institution for mental diseases

The term ''institution for mental diseases'' has the meaning given that term in section 1396d(i) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1915, as added Pub. L. 97–35, title XXI, §2175(b), Aug. 13, 1981, 95 Stat. 809; amended Pub. L. 97–35, title XXI, §§2176, 2177(a), Aug. 13, 1981, 95 Stat. 812, 813; Pub. L. 97–248, title I, §137(b)(19)(A), (20)–(25), Sept. 3, 1982, 96 Stat. 380; Pub. L. 97–448, title III, §309(b)(17), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–369, div. B, title III, §2373(b)(21), July 18, 1984, 98 Stat. 1112; Pub. L. 99–272, title IX, §§9502(a)–(e), (g)–(i), 9508(a), Apr. 7, 1986, 100 Stat. 202–204, 210; Pub. L. 99–509, title IX, §§9320(h)(3), 9411(a)–(d), Oct. 21, 1986, 100 Stat. 2016, 2061, 2062; Pub. L. 100–93, §8(h)(2), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§4072(d), 4102(a)(1), (b)(2), 4118(a)(1), (b), (i)(1), (k), (*l*)(1), (p)(10), 4211(h)(10), Dec. 22, 1987, 101 Stat. 1330–117, 1330–143, 1330–146, 1330–154 to 1330–157, 1330–160, 1330–206; Pub. L. 100–360, title II, §204(d)(3), title IV, §411(k)(3), (10)(A), (H), (I), (17)(A), (*l*)(3)(G), July 1, 1988, 102 Stat. 729, 791, 794, 796, 799, 803; Pub. L. 100–485, title VI, §608(d)(26)(M), (f)(2), Oct. 13, 1988, 102 Stat. 2422, 2424; Pub. L. 100–647, title VIII, §§8432(a), (b), 8437(a), Nov. 10, 1988, 102 Stat. 3804, 3806; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6115(c), 6411(c)(2), Dec. 19, 1989, 103 Stat. 2219, 2270; Pub. L. 101–508, title IV, §§4604(c), 4704(b)(3), 4741, 4742(a), (c)(1), (d)(1), Nov. 5, 1990, 104 Stat. 1388–169, 1388–172, 1388–197, 1388–198; Pub. L. 102–119, §26(i)(2), Oct. 7, 1991, 105 Stat. 607; Pub. L. 103–66, title XIII, §13603(d), Aug. 10, 1993, 107 Stat. 620; Pub. L. 105–33, title IV, §§4106(c), 4743(a), Aug. 5, 1997, 111 Stat. 368, 524; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(*o*), (z)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397, 1501A–398; Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574; Pub. L. 107–121, §2(b)(3), Jan. 15, 2002, 115 Stat. 2384; Pub. L. 108–446, title III, §305(j)(2), Dec. 3, 2004, 118 Stat. 2806; Pub. L. 109–171, title VI, §§6052(a), 6086(a), 6087(a), Feb. 8, 2006, 120 Stat. 93, 121, 127; Pub. L. 111–148, title II, §§2401, 2402(b), (c), (e), (f), 2601(a), (b)(1), Mar. 23, 2010, 124 Stat. 297, 302–304, 314, 315; Pub. L. 111–152, title I, §1205, Mar. 30, 2010, 124 Stat. 1056; Pub. L. 115–271, title V, §5052(a)(2), Oct. 24, 2018, 132 Stat. 3971; Pub. L. 118–42, div. G, title I, §204(a)–(c)(1)(A), (2), (3), Mar. 9, 2024, 138 Stat. 403–405.)

APPLICABILITY OF AMENDMENT

Amendment by section 204(c)(1)(A) of title I of div. G of Pub. L. 118–42 applicable with respect to States providing medical assistance for items and services pursuant to a State plan amendment under subsection (l) of this section in calendar quarters beginning on or after Oct. 1, 2025. See 2024 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (g)(5), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVI of the Act is classified generally to subchapter XXIV (§300ff et seq.) of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 7702B(c)(2)(B) of the Internal Revenue Code of 1986, referred to in subsec. (i)(1)(D)(i), (F)(i), is classified to section 7702B(c)(2)(B) of Title 26, Internal Revenue Code.

The Individuals with Disabilities Education Act, referred to in subsec. (k)(1)(C)(ii), is title VI of Pub. L. 91–230, Apr. 13, 1970, 84 Stat. 175, which is classified generally to chapter 33 (§1400 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Rehabilitation Act of 1973, referred to in subsec. (k)(1)(C)(ii), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355, which is classified generally to chapter 16 (§701 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

The Fair Labor Standards Act of 1938, referred to in subsec. (k)(4), is act June 25, 1938, ch. 676, 52 Stat. 1060, which is classified generally to chapter 8 (§201 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see section 201 of Title 29 and Tables.

The Consolidated Appropriations Act, 2024, referred to in subsec. (*l*)(3)(D), is Pub. L. 118–42, Mar. 9, 2024, 138 Stat. 25. For complete classification of this Act to the Code, see Tables.

AMENDMENTS

2024—Subsec. (*l*)(1). Pub. L. 118–42, §204(a), substituted ''With respect to calendar quarters beginning on or after October 1, 2019,'' for ''With respect to calendar quarters beginning during the period beginning October 1, 2019, and ending September 30, 2023,''.

Subsec. (*l*)(3)(A). Pub. L. 118–42, §204(b)(1), substituted ''from non-Federal funds for items and services (including services described in subparagraph (B))'' for ''other than under this subchapter from non-Federal funds for—

''(i) items and services furnished to eligible individuals who are patients in eligible institutions for mental diseases that is not less than the level of such funding for such items and services for the most recently ended fiscal year as of October 24, 2018, or, if higher, for the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection; and

''(ii) items and services (including services described in subparagraph (B))''

and ''such items and services for, at the option of the State—'' and cls. (i) and (ii) for ''such items and services for the most recently ended fiscal year as of October 24, 2018, or, if higher, for the most recently ended

fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection.''

Subsec. (*l*)(3)(B). Pub. L. 118–42, § 204(b)(2), substituted ''subparagraph (A)'' for ''subparagraph (A)(ii)'' in introductory provisions.

Subsec. (*l*)(3)(D). Pub. L. 118–42, § 204(b)(3), added subpar. (D).

Subsec. (*l*)(4)(A). Pub. L. 118–42, § 204(c)(1)(A)(i), substituted ''through (F)'' for ''through (D)''.

Subsec. (*l*)(4)(B). Pub. L. 118–42, § 204(c)(1)(A)(ii), substituted ''The State shall have in place evidence-based, substance use disorder-specific individual placement criteria and utilization management approaches to ensure placement of eligible individuals in an appropriate level of care, including criteria and approaches to ensure'' for ''Prior to approval of a State plan amendment under this subsection, the State shall notify the Secretary of how the State will ensure'' and inserted at end ''The State shall notify the Secretary at such time and in such form and manner as the Secretary shall require of such criteria and utilization management approaches.''

Subsec. (*l*)(4)(C)(ii). Pub. L. 118–42, § 204(c)(3)(A), which directed substitution of ''conditions'' for ''problems in Dimensions 1, 2, or 3'' each place it appears, was executed by making the substitution in subcl. (IV) and also making the substitution in subcl. (V) for ''problems in Dimensions 1, 2 or 3'', to reflect the probable intent of Congress.

Subsec. (*l*)(4)(E). Pub. L. 118–42, § 204(c)(1)(A)(iii), added subpar. (E).

Subsec. (*l*)(4)(F). Pub. L. 118–42, § 204(c)(2), added subpar. (F).

Subsec. (*l*)(7). Pub. L. 118–42, § 204(c)(3)(B), redesignated subpars. (B) to (D) as (A) to (C), respectively, and struck out former subpar. (A). Prior to amendment, text of subpar. (A) read as follows: ''The term 'Dimensions 1, 2, or 3' has the meaning given that term for purposes of the publication of the American Society of Addiction Medicine entitled 'The ASAM Criteria: Treatment Criteria for Addictive Substance-Related, and Co-Occurring Conditions, 2013'.''

2018—Subsec. (*l*). Pub. L. 115–271 added subsec. (*l*).

2010—Subsec. (b). Pub. L. 111–148, § 2601(b)(1)(A), inserted at end of concluding provisions ''Subsection (h)(2) shall apply to a waiver under this subsection.''

Subsec. (c)(3). Pub. L. 111–148, § 2601(b)(1)(B), inserted ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection''.

Subsec. (d)(3). Pub. L. 111–148, § 2601(b)(1)(C), which directed insertion of ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection'' in second sentence, was executed by making the insertion after ''a waiver under this subsection'', to reflect the probable intent of Congress.

Subsec. (h). Pub. L. 111–148, § 2601(a), designated existing provisions as par. (1), inserted '', or a waiver described in paragraph (2)'' after ''(c), (d), or (e)'', and added par. (2).

Subsec. (i)(1). Pub. L. 111–148, § 2402(c), struck out ''or such other services requested by the State as the Secretary may approve'' after ''room and board''.

Subsec. (i)(1)(C). Pub. L. 111–148, § 2402(e)(1), added subpar. (C) and struck out former subpar. (C) which related to projection of number of individuals to be provided home and community-based services and State authority to limit number of eligible individuals.

Subsec. (i)(1)(D)(ii)(II). Pub. L. 111–148, § 2402(e)(2), substituted ''to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria'' for ''to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services''.

Subsec. (i)(3). Pub. L. 111–148, § 2402(f), substituted ''1396a(a)(10)(B) of this title (relating to comparability)'' for ''1396a(a)(1) of this title (relating to statewideness)''.

Subsec. (i)(6), (7). Pub. L. 111–148, § 2402(b), added pars. (6) and (7).

Subsec. (k). Pub. L. 111–148, § 2401, added subsec. (k).

Subsec. (k)(1). Pub. L. 111–152 substituted ''October 1, 2011'' for ''October 1, 2010'' in introductory provisions.

2006—Subsec. (g)(2) to (5). Pub. L. 109–171, § 6052(a), added pars. (2) to (5) and struck out former par. (2), which read as follows: ''For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.''

Subsec. (i). Pub. L. 109–171, § 6086(a), added subsec. (i).

Subsec. (j). Pub. L. 109–171, § 6087(a), added subsec. (j).

2004—Subsec. (c)(5)(C)(i). Pub. L. 108–446, which directed the substitution of ''(as such terms are defined in section 1401 of title 20)'' for ''as defined in section 1401(16) and (17) of title 20)'', was executed by making the substitution for ''(as defined in paragraphs (16) and (17) of section 1401(a) of title 20)'' to reflect the probable intent of Congress and the amendment by Pub. L. 102–119. See 1991 Amendment note below.

2002—Subsec. (b). Pub. L. 107–121 substituted ''1396a(bb)'' for ''1396a(aa)''.

2000—Subsec. (b). Pub. L. 106–554 substituted ''1396a(a)(15), 1396a(aa),'' for ''1396a(a)(13)(C)'' in introductory provisions.

1999—Subsec. (b). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(z)], which directed, effective Oct. 1, 2004, substitution of ''section'' for ''sections 1396a(a)(13)(C) and'' in introductory provisions, could not be executed due to the amendment by Pub. L. 106–554. See 2000 Amendment note above.

Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(*o*)(1)], substituted ''1396a(a)(13)(C)'' for ''1396a(a)(13)(E)'' in introductory provisions.

Subsec. (d)(5)(B)(iii). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(*o*)(2)], which directed substitution of ''65'' for ''75'' in last sentence of cl. (iii), was executed by making the substitution in the penultimate sentence to reflect the probable intent of Congress.

Subsec. (h). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(*o*)(3)], substituted ''90 days of such date'' for ''90 day of such date''.

1997—Subsec. (a)(1)(B)(ii)(I). Pub. L. 105–33, § 4106(c), substituted ''paragraphs (16) and (17)'' for ''paragraphs (15) and (16)''.

Subsec. (c)(5). Pub. L. 105–33, § 4743(a), in introductory provisions, struck out '', with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded'' after '' 'habilitation services' ''.

1993—Subsec. (g)(1). Pub. L. 103–66 inserted ''or to individuals described in section 1396a(z)(1)(A) of this title'' after ''or with either,''.

1991—Subsec. (c)(5)(C)(i). Pub. L. 102–119 substituted ''(as defined in paragraphs (16) and (17) of section 1401(a) of title 20)'' for ''(as defined in section 1401(16) and (17) of title 20)''. The reference to section 1401 of title 20 includes the substitution of ''Individuals with Disabilities Education Act'' for ''Education of the Handicapped Act'' in the original.

1990—Subsec. (b). Pub. L. 101–508, § 4704(b)(3), inserted ''(other than sections 1396a(a)(13)(E) and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title)'' after ''section 1396a of this title'' in introductory provisions.

Pub. L. 101–508, § 4604(c), which directed amendment of subsec. (b) by inserting ''(other than subsection (s))'' after ''Section 1396a of this title'', was executed by inserting the new language after ''section 1396a of this title'' to reflect the probable intent of Congress.

Subsec. (b)(4). Pub. L. 101–508, § 4742(a), inserted before period at end ''and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A) of this title''.

Subsec. (c)(1). Pub. L. 101–508, § 4741(a), inserted at end ''For purposes of this subsection, the term 'room and

board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.''

Subsec. (c)(4). Pub. L. 101–508, §4742(d)(1), inserted at end ''Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.''

Subsec. (c)(7)(C). Pub. L. 101–508, §4742(c)(1), added subpar. (C).

Subsec. (d)(1). Pub. L. 101–508, §4741(a), inserted at end ''For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.''

Subsec. (d)(5)(B)(iv). Pub. L. 101–508, §4741(b), substituted ''this subchapter whose provisions become effective on or after such date'' for first reference to ''this subchapter''.

1989—Subsec. (a)(1)(B)(ii)(I). Pub. L. 101–239, §6115(c), substituted ''paragraphs (15) and (16)'' for ''paragraphs (14) and (15)''.

Pub. L. 101–234, which repealed Pub. L. 100–360, §204(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was not executed in view of intervening amendments made to this section by Pub. L. 101–239, §6115(c), and to section 1395x(s) of this title by Pub. L. 101–239, §6115(a)(1)(C). See 1988 Amendment note below.

Subsec. (b)(4). Pub. L. 101–239, §6411(c)(2), inserted ''shall be consistent with the requirements of section 1396r–4 of this title and'' after ''which standards''.

1988—Subsec. (a)(1)(B)(ii)(I). Pub. L. 100–360, §204(d)(3), substituted ''paragraphs (14) and (15)'' for ''paragraphs (13) and (14)''.

Subsec. (a)(2). Pub. L. 100–485, §608(f)(2), substituted ''restricts'' for ''Restricts'' in introductory provisions.

Subsec. (c)(7). Pub. L. 100–360, §411(*l*)(3)(G), amended Pub. L. 100–203, §4211(h)(10)(G), see 1987 Amendment note below.

Subsec. (c)(7)(A). Pub. L. 100–647, §8437(a), substituted ''who are inpatients in, or who would require the level of care provided in, hospitals,'' for ''who are inpatients in hospitals,'' and ''who are inpatients in, or who would require the level of care provided in, those respective facilities'' for ''who are inpatients of those respective facilities''.

Subsec. (c)(7)(B). Pub. L. 100–360, §411(k)(10)(H), inserted '', without regard to the availability of beds for such inpatients'' before period at end.

Subsec. (c)(10). Pub. L. 100–360, §411(k)(10)(A), substituted ''The Secretary shall not limit to fewer than 200'' for ''No waiver under this subsection shall limit by an amount less than 200'' and ''under a waiver under this subsection'' for ''under such waiver''.

Subsec. (d)(5)(B)(i), (ii). Pub. L. 100–647, §8432(b), in introductory provisions, substituted ''the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year'' for ''the number of years beginning after the base year and ending before the waiver year'', in subcls. (I) and (II), substituted ''between the beginning of the base year and the beginning of the waiver year'' for ''between the base year and the waiver year'', and in subcl. (III), inserted ''(rounded to the nearest quarter of a year)'' after ''for each year'' and substituted ''at the end of the waiver year'' for ''before the waiver year''.

Subsec. (d)(5)(B)(iii). Pub. L. 100–360, §411(k)(3)(A)(ii), inserted before last sentence ''The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.''

Subsec. (d)(5)(B)(iii)(III). Pub. L. 100–360, §411(k)(3)(A)(i), substituted ''65'' for ''75''.

Subsec. (d)(5)(B)(iv). Pub. L. 100–647, §8432(a), added cl. (iv).

Subsec. (d)(5)(C)(i). Pub. L. 100–360, §411(k)(3)(B), substituted ''paragraph (4), and personal care services'' for ''paragraph (4)(B), personal care services, and services furnished pursuant to a waiver under subsection (c) of this section''.

Subsec. (e). Pub. L. 100–360, §411(k)(17)(A)(ii), (iii), added subsec. (e), redesignated former subsec. (e)(1) as (f)(1), and struck out former subsec. (e)(2) which read as follows: ''The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section.''

Subsec. (f)(1). Pub. L. 100–360, §411(k)(17)(A)(ii), redesignated former subsec. (e)(1) as (f)(1).

Subsec. (f)(2). Pub. L. 100–360, §411(k)(17)(A)(i), redesignated former subsec. (f) as subsec. (f)(2).

Subsec. (h). Pub. L. 100–360, §411(k)(10)(I), made technical amendment to directory language of Pub. L. 100–203, §4118(*l*)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(k)(17)(A)(iv), as amended by Pub. L. 100–485, §608(d)(26)(M), substituted '', (d), or (e)'' for ''or (d)''.

1987—Subsec. (a)(1)(B)(ii)(I). Pub. L. 100–203, §4072(d), substituted ''paragraphs (13) and (14)'' for ''paragraphs (12) and (13)''.

Subsec. (a)(2). Pub. L. 100–93 amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''restricts—

''(A) for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or

''(B) (through suspension or otherwise) for a reasonable period of time the participation of a provider of items or services under the State plan, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the provider has (in a significant number or proportion of cases) provided such items or services either (i) at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or (ii) of a quality which does not meet professionally recognized standards of health care,

if, under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.''

Subsec. (c)(1). Pub. L. 100–203, §4211(h)(10)(A), substituted ''nursing facility or intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility''.

Subsec. (c)(2)(B). Pub. L. 100–203, §4211(h)(10)(C), in closing provisions, substituted ''need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded'' for ''need for such inpatient hospital, skilled nursing facility or intermediate care facility services''.

Pub. L. 100–203, §4118(p)(10), amended Pub. L. 99–509, §9411(a)(2). See 1986 Amendment note below.

Subsec. (c)(2)(B)(i). Pub. L. 100–203, §4211(h)(10)(B), substituted ''services, nursing facility services, or services in an intermediate care facility for the mentally retarded'' for '', skilled nursing facility, or intermediate care facility services''.

Subsec. (c)(2)(C). Pub. L. 100–203, §4211(h)(10)(D), (E), substituted '', nursing facility, or intermediate care fa-

cility for the mentally retarded'' for ''or skilled nursing facility or intermediate care facility'' and '', nursing facility services, or services in an intermediate care facility for the mentally retarded'' for ''or skilled nursing facility or intermediate care facility services''.

Subsec. (c)(3). Pub. L. 100–203, § 4118(a)(1), substituted '', section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community)'' for ''and section 1396a(a)(10)(B) of this title (relating to comparability)''.

Subsec. (c)(5). Pub. L. 100–203, § 4211(h)(10)(F), substituted ''nursing facility or intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility''.

Subsec. (c)(7). Pub. L. 100–203, § 4211(h)(10)(G), as amended by Pub. L. 100–360, § 411(*l*)(3)(G), substituted '', nursing facilities, or intermediate care facilities for the mentally retarded'' for ''or in skilled nursing or intermediate care facilities'' in subpar. (A) and ''nursing facility'' for ''skilled nursing facility or intermediate care facility'' in subpar. (B).

Pub. L. 100–203, § 4118(k), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(10). Pub. L. 100–203, § 4118(b), added par. (10).

Subsec. (d). Pub. L. 100–203, § 4102(a)(1), added subsec. (d). Former subsec. (d) redesignated (h).

Subsec. (g)(1). Pub. L. 100–203, § 4118(i)(1), inserted at end ''The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.''

Subsec. (h). Pub. L. 100–203, § 4118(*l*)(1), as amended by Pub. L. 100–360, § 411(k)(10)(I), substituted '', within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 day of such date, denies such request.'' for ''denies such request in writing within 90 days after the date of its submission to the Secretary.''

Pub. L. 100–203, § 4102(b)(2), substituted ''subsection (c) or (d)'' for ''subsection (c)''.

Pub. L. 100–203, § 4102(a)(1)(A), redesignated former subsec. (d) as (h).

1986—Subsec. (a)(1)(B)(ii)(I). Pub. L. 99–509, § 9320(h)(3), substituted ''paragraphs (12) and (13)'' for ''paragraphs (11) and (12)''.

Subsec. (b). Pub. L. 99–272, § 9508(a)(2), inserted provision, following par. (4), that no waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title.

Subsec. (c)(1). Pub. L. 99–509, § 9411(a)(1), inserted ''a hospital or'' after ''level of care provided in'', and struck out provision added by Pub. L. 99–272, § 9502(b)(1).

Pub. L. 99–272, § 9502(b)(1), inserted provision relating to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would continue to receive inpatient hospital services, skilled nursing facility services, or intermediate care facility services because they are dependent on ventilator support the cost of which is reimbursed under the State plan.

Subsec. (c)(2)(B). Pub. L. 99–509, § 9411(a)(2), as amended by Pub. L. 100–203, § 4118(p)(10), substituted ''inpatient hospital, skilled nursing facility, or'' for ''skilled nursing facility or'' in cl. (i) and inserted ''inpatient hospital,'' after ''need for such'' in concluding provision following cl. (iii).

Subsec. (c)(2)(C). Pub. L. 99–272, § 9502(b)(2), inserted ''hospital or'' after ''provided in a'', and ''inpatient hospital services or'' after ''the provision of''.

Subsec. (c)(2)(D). Pub. L. 99–272, § 9502(c)(1), inserted ''100 percent of'' after ''does not exceed''.

Subsec. (c)(3). Pub. L. 99–509, § 9411(c), substituted ''and section 1396a(a)(10)(B) of this title (relating to comparability)'' for ''and section 1396a(a)(10) of this title''.

Pub. L. 99–272, § 9502(g), substituted ''additional five-year periods'' for ''additional three-year periods'', and ''previous waiver period'' for ''previous three-year period''.

Pub. L. 99–272, § 9502(e), inserted at end ''A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.''

Subsec. (c)(4)(B). Pub. L. 99–509, § 9411(d), inserted before the period ''and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness''.

Subsec. (c)(5). Pub. L. 99–272, § 9502(a), added par. (5).

Subsec. (c)(6). Pub. L. 99–272, § 9502(c)(2), added par. (6).

Subsec. (c)(7). Pub. L. 99–509, § 9411(a)(3), amended par. (7) generally. Prior to amendment, par. (7) read as follows: ''In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those facilities.''

Pub. L. 99–272, § 9502(d), added par. (7).

Subsec. (c)(8). Pub. L. 99–272, § 9502(h), added par. (8).

Subsec. (c)(9). Pub. L. 99–272, § 9502(i), added par. (9).

Subsec. (g). Pub. L. 99–272, § 9508(a)(1), added subsec. (g).

Subsec. (g)(1). Pub. L. 99–509, § 9411(b), inserted provision at end allowing a State to limit case management services to AIDS victims or to individuals with chronic mental illness.

1984—Subsec. (c)(1). Pub. L. 98–369 substituted ''under this subchapter'' for ''under this part''.

1983—Subsec. (c)(2)(B). Pub. L. 97–448 substituted ''need for such skilled nursing facility or intermediate care facility services'' for ''need for such services'' in provisions following cl. (iii).

1982—Subsec. (b). Pub. L. 97–248, § 137(b)(19)(A), struck out ''and section 1396b(m) of this title'' after ''section 1396a of this title''.

Subsec. (b)(1). Pub. L. 97–248, § 137(b)(20), inserted ''primary care'' before ''case-management system'', and substituted ''medical care services'' for ''primary care services''.

Subsec. (c)(1). Pub. L. 97–248, § 137(b)(21), inserted ''payment for part or all of the cost of'' after ''may include as 'medical assistance' under such plan''.

Subsec. (c)(2)(B). Pub. L. 97–248, § 137(b)(22), redesignated existing provisions as cls. (i) and (ii) and added cl. (iii).

Subsec. (c)(3). Pub. L. 97–248, § 137(b)(23), substituted ''section 1396a(a)(1) of this title'' for ''subsection (a)(1) of this section'' and ''section 1396a(a)(10) of this title'' for ''subsection (a)(10) of section 1396a of this title''.

Subsec. (c)(4). Pub. L. 97–248, § 137(b)(24), substituted ''this subsection'' for ''this section''.

Subsec. (f). Pub. L. 97–248, § 137(b)(25), inserted ''approval of'' before ''a proposed State plan''.

1981—Subsecs. (c) to (e). Pub. L. 97–35, § 2176, added subsec. (c), redesignated former subsec. (c) as (d) and inserted ''(other than a waiver under subsection (c))'', and redesignated former subsec. (d) as (e).

Subsec. (f). Pub. L. 97–35, § 2177(a), added subsec. (f).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–42, div. G, title I, §204(c)(1)(B), Mar. 9, 2024, 138 Stat. 404, provided that: ''The amendments made by subparagraph (A) [amending this section] shall apply with respect to States providing medical assistance for items and services pursuant to a State plan amendment under section 1915(*l*) of the Social Security Act (42 U.S.C. 1396n(*l*)) in calendar quarters beginning on or after October 1, 2025.''

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2402(b), (c), (e), (f) 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.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6052(c), Feb. 8, 2006, 120 Stat. 95, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2006.''

Pub. L. 109–171, title VI, §6086(c), Feb. 8, 2006, 120 Stat. 127, provided that: ''The amendments made by subsections (a) and (b) [amending this section] take effect on January 1, 2007, and apply to expenditures for medical assistance for home and community-based services provided in accordance with section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)] (as added by subsections (a) and (b) [probably means subsec. (a)]) on or after that date.''

Pub. L. 109–171, title VI, §6087(b), Feb. 8, 2006, 120 Stat. 130, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 2007.''

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–121 effective as if included in the enactment of section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 as enacted into law by section 1(a)(6) of Pub. L. 106–554, see section 2(c)(2) of Pub. L. 107–121, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective Jan. 1, 2001, and applicable to services furnished on or after such date, see section 1(a)(6) [title VII, §702(e)] of Pub. L. 106–554, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(z)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that the amendment made by section 1000(a)(6) [title VI, §608(z)] is effective Oct. 1, 2004.

Amendment by section 1000(a)(6) [title VI, §608*o*] 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 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4743(b), Aug. 5, 1997, 111 Stat. 524, provided that: ''The amendment made by subsection (a) [amending this section] apply to services furnished on or after October 1, 1997.''

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by 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.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4604(c) of Pub. L. 101–508 effective with respect 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 4604 of Pub. L. 101–508 have been promulgated by such date, see section 4604(d) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4704(b)(3) 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.

Pub. L. 101–508, title IV, §4742(b), Nov. 5, 1990, 104 Stat. 1388–197, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect as of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4742(c)(2), Nov. 5, 1990, 104 Stat. 1388–198, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35], but shall only apply to facilities the participation of which under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] is terminated on or after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4742(d)(2), Nov. 5, 1990, 104 Stat. 1388–198, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35].''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Pub. L. 101–239, title VI, §6411(c)(4), Dec. 19, 1989, 103 Stat. 2270, provided that: ''The amendment made by paragraph (2) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

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 AMENDMENT

Pub. L. 100–647, title VIII, §8432(c), Nov. 10, 1988, 102 Stat. 3804, provided that: ''The amendments made by this section [amending this section] shall apply to waiver years beginning during or after fiscal year 1989.''

Pub. L. 100–647, title VIII, §8437(b), Nov. 10, 1988, 102 Stat. 3806, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to waiver applications submitted before, on, or after the date of the enactment of this Act [Nov. 10, 1988].''

Amendment by section 608(d)(26)(M) 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)(2) 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 204(d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(3), (10)(A), (H),

(I), (17)(A), (*l*)(3)(G) 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.

EFFECTIVE DATE OF 1987 AMENDMENT

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Pub. L. 100–203, title IV, § 4102(a)(2), Dec. 22, 1987, 101 Stat. 1330–146, provided that: ''The amendments made by paragraph (1) [amending this section] shall become effective on January 1, 1988.''

Pub. L. 100–203 , title IV, § 4118(a)(2), Dec. 22, 1987, 101 Stat. 1330–155, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Pub. L. 100–203, title IV, § 4118(i)(2), Dec. 22, 1987, 101 Stat. 1330–156, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect as though it were included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].''

Pub. L. 100–203, title IV, § 4118(*l*)(2), Dec. 22, 1987, 101 Stat. 1330–157, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to requests for continuation of waivers received after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, § 4118(p)(10), Dec. 22, 1987, 101 Stat. 1330–160, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Amendment by section 4211(h)(10) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r 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.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, § 9411(e), Oct. 21, 1986, 100 Stat. 2062, provided that: ''The amendments made by this section [amending this section] shall apply to applications for waivers (or renewals thereof) approved on or after the date of the enactment of this Act [Oct. 21, 1986].''

Pub. L. 99–272, title IX, § 9502(j), Apr. 7, 1986, 100 Stat. 204, as amended by Pub. L. 99–509, title IX, § 9435(a), Oct. 21, 1986, 100 Stat. 2069; Pub. L. 100–203, title IV, § 4118(j), Dec. 22, 1987, 101 Stat. 1330–156, provided that:

''(1) HABILITATION SERVICES.—The amendment made by subsection (a) [amending this section] shall be effective for services furnished on or after the date of the enactment of this Act [Apr. 7, 1986] to individuals eligible for services under a waiver granted under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)], without regard to whether such individuals were receiving institutional services before their participation in the waiver.

''(2) HOSPITALIZED PATIENTS.—The amendments made by subsection (b) [amending this section] shall be effective for services furnished on or after October 1, 1985.

''(3) PROHIBITION OF REGULATORY LIMITS AND TREATMENT OF CERTAIN PHYSICALLY DISABLED INDIVIDUALS.—The amendments made by subsections (c) and (d) [amending this section] shall apply to applications for waivers (or renewals thereof) filed before, on, or after, the date of the enactment of this Act [Apr. 7, 1986] and for services furnished on or after August 13, 1981.

''(4) INCOME STANDARDS.—The amendment made by subsection (e) [amending this section] shall apply to waivers (or renewals thereof) approved before, on, or after the date of the enactment of this Act [Apr. 7, 1986].

''(5) WAIVER EXTENSIONS.—Subsection (f) [enacting provisions set out below] shall apply to waivers expiring on or after September 30, 1985, and before September 30, 1986.

''(6) WAIVER RENEWALS.—The amendments made by subsection (g) [amending this section] shall become effective on September 30, 1986.

''(7) COORDINATED SERVICES AND SUBSTITUTION OF PARTICIPANTS.—The amendments made by subsections (h) and (i) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

Pub. L. 99–272, title IX, § 9508(b), Apr. 7, 1986, 100 Stat. 211, as amended by Pub. L. 99–509, title IX, § 9435(d)(1), Oct. 21, 1986, 100 Stat. 2070, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Apr. 7, 1986], without regard to whether or not regulations to carry out the amendments have been promulgated by that date.''

[Pub. L. 100–203, title IV, § 4118(j), Dec. 22, 1987, 101 Stat. 1330–156, provided that the amendment made by that section to section 9502(j)(1) of Pub. L. 99–272, set out above, is effective as if included in the enactment of section 9502 of Pub. L. 99–272.]

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, § 137(b)(19)(B), Sept. 3, 1982, 96 Stat. 380, provided that: ''The amendment made by subparagraph (A) [amending this section] shall not apply with respect to any waiver if such waiver was granted, and the arrangement covered by the waiver was in place, prior to August 10, 1982.''

Amendment by section 137(b)(20)–(25) 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

Pub. L. 97–35, title XXI, § 2177(b), Aug. 13, 1981, 95 Stat. 813, provided that: ''The amendment made by this section [amending this section] shall become effective 90 days after the date of the enactment of this Act [Aug. 13, 1981]''.

REGULATIONS

Pub. L. 109–171, title VI, § 6052(b), Feb. 8, 2006, 120 Stat. 95, provided that: ''The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) [amending this section] which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.''

CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title V, § 5052(b), Oct. 24, 2018, 132 Stat. 3976, provided that: ''Nothing in the amendments made by subsection (a) [amending this section and section 1396d of this title] shall be construed as encouraging a State to place an individual in an inpatient or a residential care setting where a home or community-based care setting would be more appropriate for the individual, or as preventing a State from conducting or pursuing a demonstration project under section 1115 of the Social Security Act [42 U.S.C. 1315] to improve access to, and the quality of, substance use disorder treatment for eligible populations.''

APPLICATION TO CERTAIN STATES

Pub. L. 118–42, div. G, title I, § 204(d), Mar. 9, 2024, 138 Stat. 405, provided that: ''Notwithstanding section 430.20 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services may approve a request to renew a State plan amendment under section 1915(*l*) of the Social Security Act (42 U.S.C. 1396n(*l*)) with an effective date of October 1, 2023, if the State making such request—

''(1) had approval for a State plan amendment under such section as of September 30, 2023; and

''(2) submits the request to renew such amendment not later than 60 days after the date of enactment of this Act [Mar. 9, 2024].''

OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES

Pub. L. 111–148, title II, § 2402(a), Mar. 23, 2010, 124 Stat. 301, provided that: ''The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

''(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other [than] the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

''(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

''(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

''(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

''(B) oversee and monitor all service system functions to assure—

''(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

''(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

''(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.''

QUALITY OF CARE MEASURES

Pub. L. 109–171, title VI, § 6086(b), Feb. 8, 2006, 120 Stat. 127, provided that:

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

''(2) BEST PRACTICES.—The Secretary shall—

''(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

''(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

''(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection.''

PERMITTING ADJUSTMENT IN ESTIMATES TO TAKE INTO ACCOUNT PREADMISSION SCREENING REQUIREMENT

Pub. L. 101–508, title IV, § 4742(e), Nov. 5, 1990, 104 Stat. 1388–198, provided that: ''In the case of a waiver under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)] for individuals with mental retardation or a related condition in a State, the Secretary of Health and Human Services shall permit the State to adjust the estimate of average per capita expenditures submitted under paragraph (2)(D) of such section, with respect to such expenditures made on or after January 1, 1989, to take into account increases in expenditures for, or utilization of, intermediate care facilities for the mentally retarded resulting from implementation of section 1919(e)(7)(A) of such Act [42 U.S.C. 1396r(e)(7)(A)].''

EXTENSIONS OF WAIVERS UNDER SUBSECTION (c)

Pub. L. 100–203, title IV, § 4102(c), Dec. 22, 1987, 101 Stat. 1330–146, provided that: ''In the case of a State which, as of December 1, 1987, has a waiver approved with respect to elderly individuals under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)], which waiver is scheduled to expire before July 1, 1988, if the State notifies the Secretary of Health and Human Services of the State's intention to file an application for a waiver under section 1915(d) of such Act (as amended by subsection (a) of this section), the Secretary shall extend approval of the State's waiver, under section 1915(c) of such Act, on the same terms and conditions through September 30, 1988.''

Pub. L. 99–272, title IX, § 9502(f), Apr. 7, 1986, 100 Stat. 204, provided that: ''The Secretary of Health and Human Services shall extend, upon request of the State, any waiver under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)] which expires on or after September 30, 1985, and before September 30, 1986. Such extension shall be for a period of not less than one year nor more than five years, subject to section 1915(e)(1) of such Act.''

§ 1396*o*. Use of enrollment fees, premiums, deductions, cost sharing, and similar charges

(a) Imposition of certain charges under plan in case of individuals described in section 1396a(a)(10)(A) or (E)

Subject to subsections (g), (i), and (j), the State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title,

(E) services furnished to an individual who is receiving hospice care (as defined in section 1396d(*o*) of this title),

(F) any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product),

(G) COVID–19 testing-related services for which payment may be made under the State plan,

(H) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)),

(I) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), or

(J) vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines; and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ''nominal'' under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) Imposition of certain charges under plan in case of individuals other than those described in section 1396a(a)(10)(A) or (E)

The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1396a(a)(10) of this title who are eligible under the plan—

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

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institu-

tion, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title,

(E) services furnished to an individual who is receiving hospice care (as defined in section 1396d(*o*) of this title),

(F) any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product),

(G) COVID–19 testing-related services for which payment may be made under the State plan,

(H) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)),

(I) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), or

(J) vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines; and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ''nominal'' under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(c) Imposition of monthly premium; persons affected; amount; prepayment; failure to pay; use of funds from other programs

(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in subparagraph (A) or (B) of section 1396a(*l*)(1) of this title who is receiving medical assistance on the basis of section 1396a(a)(10)(A)(ii)(IX) of this title and whose family income (as determined in accordance with the methodology specified in section 1396a(*l*)(3) of this title) equals or exceeds 150 percent of the income 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.

(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be counted as income to the individual with respect to whom such payment is made.

(d) Premiums for qualified disabled and working individuals described in section 1396d(s)

With respect to a qualified disabled and working individual described in section 1396d(s) of this title whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.

(e) Prohibition of denial of services on basis of individual's inability to pay certain charges

The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or

services were furnished for payment of the deduction, cost sharing, or similar charge.

(f) Charges imposed under waiver authority of Secretary

No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) and section 1396*o*–1 of this title, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

(g) Individuals provided medical assistance under section 1396a(a)(10)(A)(ii)(XV) or (XVI)

With respect to individuals provided medical assistance only under subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title—

(1) a State may (in a uniform manner for individuals described in either such subclause)—

(A) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and

(B) require payment of 100 percent of such premiums for such year in the case of such an individual who has income for a year that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved, except that in the case of such an individual who has income for a year that does not exceed 450 percent of such poverty line, such requirement may only apply to the extent such premiums do not exceed 7.5 percent of such income; and

(2) such State shall require payment of 100 percent of such premiums for a year by such an individual whose adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) for such year exceeds $75,000, except that a State may choose to subsidize such premiums by using State funds which may not be federally matched under this subchapter.

In the case of any calendar year beginning after 2000, the dollar amount specified in paragraph (2) shall be increased in accordance with the provisions of section 415(i)(2)(A)(ii) of this title.

(h) Indexing nominal cost sharing

In applying this section and subsections (c) and (e) of section 1396*o*–1 of this title, with respect to cost sharing that is ''nominal'' in amount, the Secretary shall increase such ''nominal'' amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.

(i) State option to impose income-related premiums for families of disabled children

(1) With respect to disabled children provided medical assistance under section 1396a(a)(10)(A)(ii)(XIX) of this title, subject to paragraph (2), a State may (in a uniform manner for such children) require the families of such children to pay monthly premiums set on a sliding scale based on family income.

(2) A premium requirement imposed under paragraph (1) may only apply to the extent that—

(A) in the case of a disabled child described in that paragraph whose family income—

(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1396a(cc)(2)(A)(i) of this title and other cost-sharing charges do not exceed 5 percent of the family's income; and

(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1396a(cc)(2)(A)(i) of this title and other cost-sharing charges do not exceed 7.5 percent of the family's income; and

(B) the requirement is imposed consistent with section 1396a(cc)(2)(A)(ii)(I) of this title.

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under section 1396a(a)(10)(A)(ii)(XIX) of this title for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(j) No premiums or cost sharing for Indians furnished items or services directly by Indian health programs or through referral under contract health services

(1) No cost sharing for items or services furnished to Indians through Indian health programs

(A) In general

No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this subchapter.

(B) No reduction in amount of payment to Indian health providers

Payment due under this subchapter to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such subchapter, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(2) Rule of construction

Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this subchapter who is an Indian.

(Aug. 14, 1935, ch. 531, title XIX, §1916, as added Pub. L. 97–248, title I, §131(b), Sept. 3, 1982, 96 Stat. 367; amended Pub. L. 97–448, title III, §309(b)(18)–(20), Jan. 12, 1983, 96 Stat. 2409, 2410; Pub. L. 99–272, title IX, §9505(c)(2), Apr. 7, 1986, 100 Stat. 209; Pub. L. 99–509, title IX, §9403(g)(4)(B), Oct. 21, 1986, 100 Stat. 2056; Pub. L. 100–203, title IV, §§4101(d)(1), 4211(h)(11), Dec. 22, 1987, 101 Stat. 1330–142, 1330–207; Pub. L. 100–360, title IV, §411(k)(2), July 1, 1988, 102 Stat. 791; Pub. L. 101–239, title VI, §6408(d)(3), Dec. 19, 1989, 103 Stat. 2269; Pub. L. 105–33, title IV, §4708(b), Aug. 5, 1997, 111 Stat. 506; Pub. L. 106–170, title II, §201(a)(3), Dec. 17, 1999, 113 Stat. 1893; Pub. L. 109–171, title VI, §§6041(b), 6062(b), Feb. 8, 2006, 120 Stat. 84, 98; Pub. L. 111–5, div. B, title V, §5006(a)(1), Feb. 17, 2009, 123 Stat. 505; Pub. L. 111–148, title IV, §4107(c)(1), Mar. 23, 2010, 124 Stat. 561; Pub. L. 116–127, div. F, §6004(a)(2)(A), Mar. 18, 2020, 134 Stat. 204; Pub. L. 117–2, title IX, §9811(a)(3)(A), Mar. 11, 2021, 135 Stat. 209; Pub. L. 117–169, title I, §11405(a)(2)(A), Aug. 16, 2022, 136 Stat. 1900.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (g)(2), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (a)(2)(G). Pub. L. 117–169, §11405(a)(2)(A)(i)(I), inserted a comma after ''State plan''.

Subsec. (a)(2)(J). Pub. L. 117–169, §11405(a)(2)(A)(i)(II)–(IV), added subpar. (J).

Subsec. (b)(2)(G). Pub. L. 117–169, §11405(a)(2)(A)(ii)(I), inserted a comma after ''State plan''.

Subsec. (b)(2)(J). Pub. L. 117–169, §11405(a)(2)(A)(ii)(II)–(IV), added subpar. (J).

2021—Subsecs. (a)(2)(H), (I), (b)(2)(H), (I). Pub. L. 117–2 added subpars. (H) and (I).

2020—Subsecs. (a)(2)(F), (G), (b)(2)(F), (G). Pub. L. 116–127 added subpars. (F) and (G).

2010—Subsecs. (a)(2)(B), (b)(2)(B). Pub. L. 111–148 inserted '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title'' after ''complicate the pregnancy''.

2009—Subsec. (a). Pub. L. 111–5, §5006(a)(1)(A), substituted '', (i), and (j)'' for ''and (i)'' in introductory provisions.

Subsec. (j). Pub. L. 111–5, §5006(a)(1)(B), added subsec. (j).

2006—Subsec. (a). Pub. L. 109–171, §6062(b)(1), substituted ''subsections (g) and (i)'' for ''subsection (g)'' in introductory provisions.

Subsec. (f). Pub. L. 109–171, §6041(b)(1), inserted ''and section 1396*o*–1 of this title'' after ''(b)(3)''.

Subsec. (h). Pub. L. 109–171, §6041(b)(2), added subsec. (h).

Subsec. (i). Pub. L. 109–171, §6062(b)(2), added subsec. (i).

1999—Subsec. (a). Pub. L. 106–170, §201(a)(3)(A), substituted ''Subject to subsection (g), the State plan'' for ''The State plan'' in introductory provisions.

Subsec. (g). Pub. L. 106–170, §201(a)(3)(B), added subsec. (g).

1997—Subsec. (a)(2)(D). Pub. L. 105–33, §4708(b)(1), struck out ''or services furnished to such an individual by a health maintenance organization (as defined in section 1396b(m) of this title) in which he is enrolled,'' after ''section 1396d(a)(4)(C) of this title,''.

Subsec. (b)(2)(D). Pub. L. 105–33, §4708(b)(2), struck out ''or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1396b(m) of this title) in which he is enrolled,'' after ''section 1396d(a)(4)(C) of this title,''.

1989—Subsec. (a). Pub. L. 101–239, §6408(d)(3)(A), substituted ''subparagraph (A) or (E)(i)'' for ''subparagraph (A) or (E)'' in introductory provisions.

Subsecs. (d) to (f). Pub. L. 101–239, §6408(d)(3)(B), (C), added subsec. (d) and redesignated former subsecs. (d) and (e) as (e) and (f), respectively.

1988—Subsec. (c)(1). Pub. L. 100–360 struck out ''nonfarm'' after ''150 percent of the''.

1987—Subsec. (a)(1). Pub. L. 100–203, §4101(d)(1)(A), inserted ''(except for a premium imposed under subsection (c))'' after ''plan''.

Subsecs. (a)(2)(C), (b)(2)(C). Pub. L. 100–203, §4211(h)(11), substituted ''nursing facility, intermediate care facility for the mentally retarded'' for ''skilled nursing facility, intermediate care facility''.

Subsecs. (c) to (e). Pub. L. 100–203, §4101(d)(1)(B), (C), added subsec. (c) and redesignated former subsecs. (c) and (d) as (d) and (e), respectively.

1986—Subsec. (a). Pub. L. 99–509 substituted ''subparagraph (A) or (E) of section 1396a(a)(10) of this title'' for ''section 1396a(a)(10)(A) of this title''.

Subsec. (a)(2)(E). Pub. L. 99–272 added subpar. (E).

Subsec. (b). Pub. L. 99–509 substituted ''subparagraph (A) or (E) of section 1396a(a)(10) of this title'' for ''section 1396a(a)(10)(A) of this title''.

Subsec. (b)(2)(E). Pub. L. 99–272 added subpar. (E).

1983—Subsec. (c). Pub. L. 97–448, §309(b)(18), substituted ''subsection'' for ''subparagraph''.

Subsec. (d). Pub. L. 97–448, §309(b)(19), (20), substituted in introductory text '', except as provided in subsections (a)(3) and (b)(3)'' for ''unless authorized under this section'', and in cl. (5) substituted ''is voluntary, or makes provision'' for ''in which participation is voluntary, or in which provision is made''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022, and applicable to expenditures made under a State plan or waiver of such

plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, § 6041(c), Feb. 8, 2006, 120 Stat. 85, provided that: ''The amendments made by this section [enacting section 1396*o*–1 of this title and amending this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.''

Amendment by section 6062(b) of 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 1999 AMENDMENT

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.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by 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 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.

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by 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.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4101(d)(2), Dec. 22, 1987, 101 Stat. 1330–142, provided that: ''The amendments made by paragraph (1) [amending this section] shall become effective on July 1, 1988.''

Amendment by section 4211(h)(11) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r 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 AMENDMENT

Amendment by 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 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.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, § 131(d), formerly § 131(c), Sept. 3, 1982, 96 Stat. 370, redesignated by Pub. L. 97–448, title III, § 309(a)(8), Jan. 12, 1983, 96 Stat. 2408, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1396a of this title] shall become effective on October 1, 1982.

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, 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 these additional requirements 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 [Sept. 3, 1982].''

APPLICABILITY OF 2020 AMENDMENT TO TERRITORIES

Pub. L. 116–127, div. F, § 6004(a)(2)(C), Mar. 18, 2020, 134 Stat. 205, provided that: ''The amendments made [by] this paragraph [amending this section and section 1396*o*–1 of this title] shall apply with respect to a State plan of a territory in the same manner as a State plan of one of the 50 States.''

§ 1396*o*–1. State option for alternative premiums and cost sharing

(a) State flexibility

(1) In general

Notwithstanding sections 1396*o* and 1396a(a)(10)(B) of this title, but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) subsection (g), (i), or (j) of section 1396*o* of this title.

(2) Exemption for individuals with family income not exceeding 100 percent of the poverty line

(A) In general

Paragraph (1) and subsection (d) shall not apply, and sections 1396*o* and 1396a(a)(10)(B)

of this title shall continue to apply, in the case of an individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved.

(B) Limit on aggregate cost sharing

To the extent cost sharing under subsections (c) and (e) or under section 1396*o* of this title is imposed against individuals described in subparagraph (A), the limitation under subsection (b)(1)(B)(ii) on the total aggregate amount of cost sharing shall apply to such cost sharing for all individuals in a family described in subparagraph (A) in the same manner as such limitations apply to cost sharing and families described in subsection (b)(1)(B)(ii).

(3) Definitions

In this section:

(A) Premium

The term ''premium'' includes any enrollment fee or similar charge.

(B) Cost sharing

The term ''cost sharing'' includes any deduction, copayment, or similar charge.

(b) Limitations on exercise of authority

(1) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved—

(A) no premium may be imposed under the plan; and

(B) with respect to cost sharing—

(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(2) Individuals with family income above 150 percent of the poverty line

In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved—

(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

(3) Additional limitations

(A) Premiums

No premiums shall be imposed under this section with respect to the following:

(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1396a(a)(10)(A)(i) of this title, and including individuals with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Pregnant women.

(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1396d(*o*) of this title).

(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(v) Women who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(vi) Disabled children who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XIX) and 1396a(cc) of this title.

(vii) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

(B) Cost sharing

Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1396a(a)(10)(A)(i) of this title, and including services furnished to individuals with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or and[1] individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title).

[1] So in original.

(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1396d(*o*) of this title).

(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Emergency services (as defined by the Secretary for purposes of section 1396*o*(a)(2)(D) of this title).

(vii) Family planning services and supplies described in section 1396d(a)(4)(C) of this title.

(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(ix) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XIX) and 1396a(cc) of this title.

(x) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

(xi) Any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product), and any service described in section 1396*o*(a)(2)(G) of this title that is furnished during any such portion.

(xii) During the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)).

(xiii) During the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan).

(xiv) Vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines.

(C) Construction

Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

(4) Determinations of family income

In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this subchapter.

(5) Poverty line defined

For purposes of this section, the term ''poverty line'' has the meaning given such term in section 9902(2) of this title, including any revision required by such section.

(6) Construction

Nothing in this section shall be construed—

(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

(C) as affecting any such waiver of requirements in effect under this subchapter before February 8, 2006, with regard to the imposition of premiums and cost sharing.

(c) Special rules for cost sharing for prescription drugs

(1) In general

In order to encourage beneficiaries to use drugs (in this subsection referred to as ''preferred drugs'') identified by the State as the most (or more) cost effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may—

(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under section 1396*o* of this title, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not be imposed under subsection (a) due to the application of subsection (b)(3)(B).

(2) Limitations

(A) By income group

In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed—

(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1396*o* of this title); or

(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

(B) Limitation to nominal for exempt populations

In the case of an individual who is not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1396*o* of this title).

(C) Continued application of aggregate cap

In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under subsection (a)(2)(B) or under paragraph (1) or (2) of subsection (b), as the case may be.

(3) Waiver

In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

(4) Exclusion authority

Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).

(d) Enforceability of premiums and other cost sharing

(1) Premiums

Notwithstanding section 1396*o*(c)(3) of this title and section 1396a(a)(10)(B) of this title, a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(2) Cost sharing

Notwithstanding section 1396*o*(e) of this title or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this subchapter for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.

(e) State option for permitting hospitals to impose cost sharing for non-emergency care furnished in an emergency department

(1) In general

Notwithstanding section 1396*o* of this title and section 1396a(a)(1) of this title or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this subchapter, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

(A) Access to non-emergency room provider

The individual has actually available and accessible (as such terms are applied by the Secretary under section 1396*o*(b)(3) of this title) an alternate non-emergency services provider with respect to such services.

(B) Notice

The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1395dd of this title and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

(2) Limitations

(A) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual described in subsection (b)(1) who is not described in subparagraph (B), the cost sharing imposed

under this subsection may not exceed twice the amount determined to be nominal under section 1396*o* of this title, subject to the percent of income limitation otherwise applicable under subsection (b)(1)(B)(ii).

(B) Application to exempt populations

In the case of an individual described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in paragraph (1), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1396*o* of this title) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

(C) Continued application of aggregate cap; relation to other cost sharing

In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing applied under subsection (a)(2)(B) or under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a) or section 1396*o* of this title.

(3) Construction

Nothing in this section shall be construed—

(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1395dd of this title; or

(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

(4) Definitions

For purposes of this subsection:

(A) Non-emergency services

The term ''non-emergency services'' means any care or services furnished in an emergency department of a hospital that do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1395dd of this title.

(B) Alternate non-emergency services provider

The term ''alternative non-emergency services provider'' means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this subchapter.

(Aug. 14, 1935, ch. 531, title XIX, § 1916A, as added and amended Pub. L. 109–171, title VI, §§ 6041(a), 6042(a), 6043(a), Feb. 8, 2006, 120 Stat. 81, 85, 86; Pub. L. 109–432, div. B, title IV, § 405(a)(1)–(5), Dec. 20, 2006, 120 Stat. 2996–2998; Pub. L. 111–5, div. B, title V, § 5006(a)(2), Feb. 17, 2009, 123 Stat. 506; Pub. L. 111–148, title II, § 2102(b), title IV, § 4107(c)(2), Mar. 23, 2010, 124 Stat. 289, 561; Pub. L. 116–127, div. F, § 6004(a)(2)(B), Mar. 18, 2020, 134 Stat. 205; Pub. L. 117–2, title IX, § 9811(a)(3)(B), Mar. 11, 2021, 135 Stat. 210; Pub. L. 117–169, title I, § 11405(a)(2)(B), Aug. 16, 2022, 136 Stat. 1900.)

Editorial Notes

AMENDMENTS

2022—Subsec. (b)(3)(B)(xiv). Pub. L. 117–169 added cl. (xiv).

2021—Subsec. (b)(3)(B)(xi). Pub. L. 117–2, § 9811(a)(3)(B)(i), substituted ''any service'' for ''any visit''.

Subsec. (b)(3)(B)(xii), (xiii). Pub. L. 117–2, § 9811(a)(3)(B)(ii), added cls. (xii) and (xiii).

2020—Subsec. (b)(3)(B)(xi). Pub. L. 116–127 added cl. (xi).

2010—Subsec. (a)(1). Pub. L. 111–148, § 2102(b), substituted '', (i), or (j)'' for ''or (i)''.

Subsec. (b)(3)(B)(iii). Pub. L. 111–148, § 4107(c)(2), inserted '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title)'' after ''complicate the pregnancy''.

2009—Subsec. (b)(3)(A)(vii). Pub. L. 111–5, § 5006(a)(2)(A), added cl. (vii).

Subsec. (b)(3)(B)(x). Pub. L. 111–5, § 5006(a)(2)(B), added cl. (x).

2006—Subsec. (a)(1). Pub. L. 109–432, § 405(a)(3)(A), substituted ''subsection (g) or (i) of section 1396*o*'' for ''section 1396*o*(g)'' in second sentence.

Pub. L. 109–432, § 405(a)(1)(A), inserted ''but subject to paragraph (2),'' after ''1396a(a)(10)(B) of this title,'' and ''and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)'' after ''subsection (c)''.

Subsec. (a)(2), (3). Pub. L. 109–432, § 405(a)(1)(B), (C), added par. (2) and redesignated former par. (2) as (3).

Subsec. (b)(1), (2). Pub. L. 109–432, § 405(a)(2)(A), struck out '', subject to subsections (c)(2) and (e)(2)(A)'' after ''involved'' in introductory provisions.

Subsec. (b)(3)(A)(i). Pub. L. 109–432, § 405(a)(4)(A), substituted ''child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care'' for ''aid or assistance is made available under part B of subchapter IV to children in foster care''.

Subsec. (b)(3)(A)(vi). Pub. L. 109–432, § 405(a)(3)(B)(i), added cl. (vi).

Subsec. (b)(3)(B)(i). Pub. L. 109–432, § 405(a)(4)(B), substituted ''child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or'' for ''aid or assistance is made available under part B of subchapter IV to children in foster care''.

Subsec. (b)(3)(B)(ix). Pub. L. 109–432, § 405(a)(3)(B)(ii), added cl. (ix).

Subsec. (c). Pub. L. 109–171, § 6042(a), added subsec. (c).

Subsec. (c)(1). Pub. L. 109–432, § 405(a)(2)(B), substituted ''most (or more) cost effective'' for ''least (or less) costly effective'' in introductory provisions.

Subsec. (c)(1)(B). Pub. L. 109–432, § 405(a)(2)(C), substituted ''be imposed under subsection (a) due to the application of'' for ''otherwise be imposed under''.

Subsec. (c)(2)(B). Pub. L. 109–432, §405(a)(2)(D), substituted ''not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B)'' for ''otherwise not subject to cost sharing due to the application of subsection (b)(3)(B)''.

Subsec. (c)(2)(C). Pub. L. 109–432, §405(a)(1)(D), inserted ''under subsection (a)(2)(B) or'' after ''cost sharing applied''.

Subsec. (e). Pub. L. 109–171, §6043(a), added subsec. (e).

Subsec. (e)(2)(A). Pub. L. 109–432, §405(a)(2)(E), substituted ''Individuals with family income between 100 and 150 percent of the poverty line'' for ''For poorest beneficiaries'' in heading and ''under subsection (b)(1)(B)(ii)'' for ''under subsection (b)(1)'' in text.

Pub. L. 109–432, §405(a)(1)(E), inserted ''who is not described in subparagraph (B)'' after ''in subsection (b)(1)''.

Subsec. (e)(2)(B). Pub. L. 109–432, §405(a)(2)(F), substituted ''described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in paragraph (1)'' for ''who is otherwise not subject to cost sharing under subsection (b)(3)''.

Subsec. (e)(2)(C). Pub. L. 109–432, §405(a)(2)(G), inserted ''or section 1396*o* of this title'' after ''subsection (a)''.

Pub. L. 109–432, §405(a)(1)(D), inserted ''under subsection (a)(2)(B) or'' after ''cost sharing applied''.

Subsec. (e)(4)(A). Pub. L. 109–432, §405(a)(5), struck out ''the physician determines'' after ''a hospital that''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022 and applicable to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2102(b), Mar. 23, 2010, 124 Stat. 289, provided that the amendment made by section 2102(b) is effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

Amendment by section 4107(c)(2) of Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(a)(6), Dec. 20, 2006, 120 Stat. 2998, provided that: ''The amendments made by this subsection [amending this section] shall take effect as if included in the amendments made by sections [sic] 6041(a) of the Deficit Reduction Act of 2005 [Pub. L. 109–171], except that insofar as such amendments are to, or relate to, subsection (c) or (e) of section 1916A of the Social Security Act [42 U.S.C. 1396o–1], such amendments shall take effect as if included in the amendments made by section 6042 or 6043, respectively, of the Deficit Reduction Act of 2005 [Pub. L. 109–171].''

Pub. L. 109–171, title VI, §6042(b), Feb. 8, 2006, 120 Stat. 86, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.''

Amendment by section 6043(a) of Pub. L. 109–171 applicable to non-emergency services furnished on or after Jan. 1, 2007, see section 6043(c) of Pub. L. 109–171, set out as a note under section 1396b of this title.

EFFECTIVE DATE

Section applicable to cost sharing imposed for items and services furnished on or after Mar. 31, 2006, see section 6041(c) of Pub. L. 109–171, set out as an Effective Date of 2006 Amendment note under section 1396*o* of this title.

APPLICABILITY OF 2020 AMENDMENT TO TERRITORIES

Amendment by Pub. L. 116–127 applicable with respect to a State plan of a territory in the same manner as a State plan of one of the 50 States, see section 6004(a)(2)(C) of Pub. L. 116–127, set out as a note under section 1396*o* of this title.

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an indi-

vidual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term ''qualified State long-term care insurance partnership'' means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term ''long-term care insurance policy'' includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appro-

priate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term ''estate'', with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—

(i) the terms ''model regulation'' and ''model Act'' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term ''assets'' includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term ''assets'' includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term ''assets'' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term ''resources'' has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term ''trust'' includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may re-

quire the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for ''$500,000'', an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term ''assets'', with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term ''income'' has the meaning given such term in section 1382a of this title.

(3) The term ''institutionalized individual'' means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term ''noninstitutionalized individual'' means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term ''resources'' has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

(Aug. 14, 1935, ch. 531, title XIX, § 1917, as added Pub. L. 97–248, title I, § 132(b), Sept. 3, 1982, 96 Stat. 370; amended Pub. L. 97–448, title III, § 309(b)(21), (22), Jan. 12, 1983, 96 Stat. 2410; Pub.

L. 100–203, title IV, § 4211(h)(12), Dec. 22, 1987, 101 Stat. 1330–207; Pub. L. 100–360, title III, § 303(b), title IV, § 411(*l*)(3)(I), July 1, 1988, 102 Stat. 760, 803; Pub. L. 100–485, title VI, § 608(d)(16)(B), Oct. 13, 1988, 102 Stat. 2417; Pub. L. 101–239, title VI, § 6411(e)(1), Dec. 19, 1989, 103 Stat. 2271; Pub. L. 103–66, title XIII, §§ 13611(a)–(c), 13612(a)–(c), Aug. 10, 1993, 107 Stat. 622–628; Pub. L. 109–171, title VI, §§ 6011(a), (b), (e), 6012(a)–(c), 6014(a), 6015(b), 6016(a)–(d), 6021(a)(1), Feb. 8, 2006, 120 Stat. 61–68; Pub. L. 109–432, div. B, title IV, § 405(b)(1), Dec. 20, 2006, 120 Stat. 2998; Pub. L. 110–275, title I, § 115(a), July 15, 2008, 122 Stat. 2507; Pub. L. 111–5, div. B, title V, § 5006(c), Feb. 17, 2009, 123 Stat. 507; Pub. L. 113–67, div. A, title II, § 202(b)(3), Dec. 26, 2013, 127 Stat. 1177; Pub. L. 114–255, div. A, title V, § 5007(a), Dec. 13, 2016, 130 Stat. 1197; Pub. L. 115–123, div. E, title XII, § 53102(b)(1), Feb. 9, 2018, 132 Stat. 298.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (b)(1)(C)(iii)(II) and (c)(1)(G)(i), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2018—Subsec. (a)(1)(A). Pub. L. 115–123, § 53102(b)(1), repealed Pub. L. 113–67, § 202(b)(3), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

2016—Subsec. (d)(4)(A). Pub. L. 114–255 inserted ''the individual,'' after ''for the benefit of such individual by''.

2013—Subsec. (a)(1)(A). Pub. L. 113–67, § 202(b)(3), which directed amendment of subpar. (A) to read as follows: ''pursuant to—

''(i) the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

''(ii) rights acquired by or assigned to the State in accordance with section 1396a(a)(25)(H) of this title or section 1396k(a)(1)(A) of this title, or'',

was repealed by Pub. L. 115–123, § 53102(b)(1).

2009—Subsec. (b)(3). Pub. L. 111–5 designated existing provisions as subpar. (A) and added subpar. (B).

2008—Subsec. (b)(1)(B)(ii). Pub. L. 110–275 inserted ''(but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title)'' before period at end.

2006—Subsec. (b)(1)(C)(ii). Pub. L. 109–171, § 6021(a)(1)(A)(i), inserted ''and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))'' after ''1993,'' in introductory provisions.

Subsec. (b)(1)(C)(iii) to (vi). Pub. L. 109–171, § 6021(a)(1)(A)(ii), added cls. (iii) to (vi).

Subsec. (b)(5). Pub. L. 109–171, § 6021(a)(1)(B), added par. (5).

Subsec. (c)(1)(B)(i). Pub. L. 109–171, § 6011(a), inserted ''or in the case of any other disposal of assets made on or after February 8, 2006'' before '', 60 months''.

Subsec. (c)(1)(D). Pub. L. 109–171, § 6011(b), designated existing provisions as cl. (i), substituted ''In the case of a transfer of asset made before February 8, 2006, the date'' for ''The date'', and added cl. (ii).

Subsec. (c)(1)(E)(iv). Pub. L. 109–171, § 6016(a), added cl. (iv).

Subsec. (c)(1)(F). Pub. L. 109–171, § 6012(b), added subpar. (F).

Subsec. (c)(1)(F)(i). Pub. L. 109–432 substituted ''institutionalized individual'' for ''annuitant''.

Subsec. (c)(1)(G). Pub. L. 109–171, § 6012(c), added subpar. (G).

Subsec. (c)(1)(H). Pub. L. 109–171, § 6016(b), added subpar. (H).

Subsec. (c)(1)(I). Pub. L. 109–171, § 6016(c), added subpar. (I).

Subsec. (c)(1)(J). Pub. L. 109–171, § 6016(d), added subpar. (J).

Subsec. (c)(2). Pub. L. 109–171, § 6011(e), substituted period for semicolon at end and inserted concluding provisions.

Subsec. (e). Pub. L. 109–171, § 6012(a), added subsec. (e). Former subsec. (e) redesignated (f).

Subsec. (f). Pub. L. 109–171, § 6014(a), added subsec. (f). Former subsec. (f) redesignated (g).

Pub. L. 109–171, § 6012(a), redesignated subsec. (e) as (f).

Subsec. (g). Pub. L. 109–171, § 6015(b), added subsec. (g). Former subsec. (g) redesignated (h).

Pub. L. 109–171, § 6014(a), redesignated subsec. (f) as (g).

Subsec. (h). Pub. L. 109–171, § 6015(b), redesignated subsec. (g) as (h).

1993—Subsec. (b)(1). Pub. L. 103–66, § 13612(a), substituted ''except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:'' and subpars. (A) to (C) for ''except—'' and former subpars. (A) and (B) which read as follows:

''(A) in the case of an individual described in subsection (a)(1)(B) of this section, from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

''(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate.''

Subsec. (b)(3). Pub. L. 103–66, § 13612(b), added par. (3).

Subsec. (b)(4). Pub. L. 103–66, § 13612(c), added par. (4).

Subsec. (c)(1). Pub. L. 103–66, § 13611(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: ''In order to meet the requirements of this subsection (for purposes of section 1396a(a)(51)(B) of this title), the State plan must provide for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n(c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, or whose spouse, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

''(A) 30 months, or

''(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.''

Subsec. (c)(2)(A). Pub. L. 103–66, § 13611(a)(2)(A), substituted ''assets'' for ''resources'' in introductory provisions.

Subsec. (c)(2)(B). Pub. L. 103–66, § 13611(a)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''the resources were transferred (i) to or from (or to another for the sole benefit of) the individual's spouse, or (ii) to the individual's child described in subparagraph (A)(ii)(II);''.

Subsec. (c)(2)(C). Pub. L. 103–66, § 13611(a)(2)(C), in introductory provisions, substituted ''with regulations'' for ''with any regulations'', in cl. (i), substituted ''assets'' for ''resources'' and struck out ''or'' at end, in cl. (ii), substituted ''assets'' for ''resources'' and '', or'' for ''; or'', and added cl. (iii).

Subsec. (c)(2)(D). Pub. L. 103–66, § 13611(a)(2)(D), amended subpar. (D) generally. Prior to amendment,

subpar. (D) read as follows: ''the State determines that denial of eligibility would work an undue hardship.''

Subsec. (c)(3). Pub. L. 103–66, § 13611(a)(2)(E), added par. (3) and struck out former par. (3) which read as follows: ''In this subsection, the term 'institutionalized individual' means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.''

Subsec. (c)(4). Pub. L. 103–66, § 13611(a)(2)(F), inserted at end ''In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.''

Subsec. (d). Pub. L. 103–66, § 13611(b), added subsec. (d).

Subsec. (e). Pub. L. 103–66, § 13611(c), added subsec. (e).

1989—Subsec. (c)(1). Pub. L. 101–239, § 6411(e)(1)(A), inserted ''or whose spouse,'' after ''an institutionalized individual (as defined in paragraph (3)) who,''.

Subsec. (c)(2)(B)(i). Pub. L. 101–239, § 6411(e)(1)(B)(i), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: ''to (or to another for the sole benefit of) the community spouse, as defined in section 1396r–5(h)(2) of this title,,''.

Subsec. (c)(2)(B)(ii), (iii). Pub. L. 101–239, § 6411(e)(1)(B)(ii), struck out '', or'' after ''subparagraph (A)(ii)(II)'' in cl. (ii) and struck out cl. (iii) which read as follows: ''to (or to another for the sole benefit of) the individual's spouse if such spouse does not transfer such resources to another person other than the spouse for less than fair market value''.

1988—Subsec. (c). Pub. L. 100–360, § 303(b), amended subsec. (c) generally, substituting pars. (1) to (4) relating to taking into account certain transfers of assets, for former pars. (1) to (3) relating to denial of medical assistance, period of eligibility, and exceptions.

Subsec. (c)(1). Pub. L. 100–485, § 608(d)(16)(B)(i), substituted ''period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n(c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual'' for ''period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual's application for medical assistance under the State plan''.

Subsec. (c)(2)(A)(ii). Pub. L. 100–485, § 608(d)(16)(B)(ii), inserted subcl. (I) and (II) designations.

Subsec. (c)(2)(A)(iii). Pub. L. 100–485, § 608(d)(16)(B)(iii), substituted ''the individual becomes an institutionalized individual'' for ''of the individual's admission to the medical institution or nursing facility''.

Subsec. (c)(2)(A)(iv). Pub. L. 100–485, § 608(d)(16)(B)(iv), substituted ''the individual becomes an institutionalized individual'' for ''of such individual's admission to the medical institution or nursing facility''.

Subsec. (c)(2)(B). Pub. L. 100–485, § 608(d)(16)(B)(v), inserted cl. (i) designation, substituted ''section 1396r–5(h)(2) of this title,,'' for ''section 1396r–5(h)(2) of this title, or the individual's child who is blind or permanently and totally disabled'', and added cl. (ii).

Subsec. (c)(2)(B)(ii). Pub. L. 100–360, § 411(*l*)(3)(I), amended Pub. L. 100–203, § 4211(h)(12)(B), see 1987 Amendment note below.

Subsec. (c)(3). Pub. L. 100–485, § 608(d)(16)(B)(vi), substituted ''in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title'' for ''in a medical institution or nursing facility''.

Subsec. (c)(5). Pub. L. 100–485, § 608(d)(16)(B)(vii), added par. (5).

1987—Subsecs. (a)(1)(B)(i), (c)(2)(B)(i). Pub. L. 100–203, § 4211(h)(12)(A), substituted ''nursing facility, intermediate care facility for the mentally retarded'' for ''skilled nursing facility, intermediate care facility''.

Subsec. (c)(2)(B)(ii). Pub. L. 100–203, § 4211(h)(12)(B), as amended by Pub. L. 100–360, § 411(*l*)(3)(I), substituted ''a nursing facility'' for ''a skilled nursing facility'' in two places each in subcls. (I) and (II).

1983—Subsec. (b)(2)(B). Pub. L. 97–448, § 309(b)(21), substituted ''who'' for ''and'' before ''has lawfully resided''.

Subsec. (c)(2)(B)(iii). Pub. L. 97–448, § 309(b)(22), substituted in subcl. (I) ''can'' for ''cannot'' and struck out from subcl. (IV) the introductory word ''if''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title XII, § 53102(b)(1), Feb. 9, 2018, 132 Stat. 298, provided that the repeal of section 202(b) of Pub. L. 113–67 is effective Sept. 30, 2017, and the provisions amended by section 202(b) shall be applied and administered as if such amendments had never been enacted. In addition, such repeal by section 53102(b)(1) of Pub. L. 115–123 applicable with respect to any open claims, including claims pending, generated, or filed, after Sept. 30, 2017, see section 53102(b)(3) of Pub. L. 115–123, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, § 5007(b), Dec. 13, 2016, 130 Stat. 1197, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to trusts established on or after the date of the enactment of this Act [Dec. 13, 2016].''

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, § 115(b), July 15, 2008, 122 Stat. 2507, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect as of January 1, 2010.''

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, § 405(b)(2), Dec. 20, 2006, 120 Stat. 2998, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of section 6012 of the Deficit Reduction Act of 2005 [Pub. L. 109–171].''

Pub. L. 109–171, title VI, § 6011(c), Feb. 8, 2006, 120 Stat. 62, provided that: ''The amendments made by this section [amending this section] shall apply to transfers made on or after the date of the enactment of this Act [Feb. 8, 2006].''

Pub. L. 109–171, title VI, § 6012(d), Feb. 8, 2006, 120 Stat. 64, provided that: ''The amendments made by this section [amending this section] shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act [Feb. 8, 2006].''

Pub. L. 109–171, title VI, § 6014(b), Feb. 8, 2006, 120 Stat. 65, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term

care services based on an application filed on or after January 1, 2006.''

Pub. L. 109–171, title VI, §6016(e), Feb. 8, 2006, 120 Stat. 67, provided that:

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act [Feb. 8, 2006], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2) EXCEPTIONS.—The amendments made by this section shall not apply—

''(A) to medical assistance provided for services furnished before the date of enactment;

''(B) with respect to assets disposed of on or before the date of enactment of this Act; or

''(C) with respect to trusts established on or before the date of enactment of this Act.

''(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, 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 these additional requirements 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. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13611(e), Aug. 10, 1993, 107 Stat. 627, provided that:

''(1) The amendments made by this section [amending this section and sections 1396a and 1396r–5 of this title] shall apply, except as provided in this subsection, to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2) The amendments made by this section shall not apply—

''(A) to medical assistance provided for services furnished before October 1, 1993,

''(B) with respect to assets disposed of on or before the date of the enactment of this Act [Aug. 10, 1993], or

''(C) with respect to trusts established on or before the date of the enactment of this Act.

''(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] 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 requirements imposed by the amendment made by subsection (b) [amending this section], the State plan shall not be regarded as failing to comply with the requirements imposed by such amendment solely on the basis of its failure to meet these additional requirements 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 [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 103–66, title XIII, §13612(d), Aug. 10, 1993, 107 Stat. 628, provided that:

''(1)(A) Except as provided in subparagraph (B), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such 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 requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements imposed by such amendments solely on the basis of its failure to meet these additional requirements 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 [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(2) The amendments made by this section shall not apply to individuals who died before October 1, 1993.''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable to transfers occurring after Dec. 19, 1989, see section 6411(e)(4) of Pub. L. 101–239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by 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 303(b) of Pub. L. 100–360 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring State legislative action), without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, and subsection (c) of this section, as amended by section 303(b) of Pub. L. 100–360, applicable to resources disposed of on or after July 1, 1988, but not applicable with respect to inter-spousal transfers occurring before Oct. 1, 1989, see section 303(g)(2), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(*l*)(3)(I) 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.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r 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 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, §132(d), Sept. 3, 1982, 96 Stat. 373, provided that: ''The amendments made by this sec-

tion [enacting this section and amending section 1396a of this title] shall become effective on the date of the enactment of this Act [Sept. 3, 1982], but the provisions of section 1917(c)(2)(B) of the Social Security Act [42 U.S.C. 1396p(c)(2)(B)] shall not apply with respect to a transfer of assets which took place prior to such date of enactment.''

AVAILABILITY OF HARDSHIP WAIVERS

Pub. L. 109–171, title VI, § 6011(d), Feb. 8, 2006, 120 Stat. 62, provided that: ''Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))—

''(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

''(A) of medical care such that the individual's health or life would be endangered; or

''(B) of food, clothing, shelter, or other necessities of life; and

''(2) which provides for—

''(A) notice to recipients that an undue hardship exception exists;

''(B) a timely process for determining whether an undue hardship waiver will be granted; and

''(C) a process under which an adverse determination can be appealed.''

EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM

Pub. L. 109–171, title VI, § 6021, Feb. 8, 2006, 120 Stat. 68, as amended by Pub. L. 111–148, title VIII, § 8002(d), title X, § 10801(c), Mar. 23, 2010, 124 Stat. 847, 1015; Pub. L. 112–240, title VI, § 642(b)(3), Jan. 2, 2013, 126 Stat. 2358, provided that:

''(a) EXPANSION AUTHORITY.—

''(1) IN GENERAL.—[Amended this section.]

''(2) STATE REPORTING REQUIREMENTS.—Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act [42 U.S.C. 1396p(b)(1)(C)(iii)(VI), (v)] (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

''(3) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

''(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

''(1) benefits paid under such policies will be treated the same by all such States; and

''(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

''(c) ANNUAL REPORTS TO CONGRESS.—

''(1) IN GENERAL.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

''(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).

''(d) NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

''(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.

''(2) DUTIES.—

''(A) IN GENERAL.—The National Clearinghouse for Long-Term Care Information shall—

''(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;

''(ii) provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and

''(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

''(B) REQUIREMENT.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

''(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $3,000,000 for each of fiscal years 2006 through 2010.''

§ 1396q. Application of provisions of subchapter II relating to subpoenas

The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II, except that, in so applying such subsections, and in applying section 405(*l*) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(Aug. 14, 1935, ch. 531, title XIX, § 1918, as added Pub. L. 98–369, div. B, title III, § 2370(a), July 18,

1984, 98 Stat. 1110; amended Pub. L. 103–296, title I, § 108(d)(5), Aug. 15, 1994, 108 Stat. 1486.)

Editorial Notes

AMENDMENTS

1994—Pub. L. 103–296 inserted before period at end '', except that, in so applying such subsections, and in applying section 405(*l*) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively''.

Statutory Notes and Related Subsidiaries

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

Pub. L. 98–369, div. B, title III, § 2370(b), July 18, 1984, 98 Stat. 1110, provided that: ''The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [July 18, 1984].''

§ 1396r. Requirements for nursing facilities

(a) "Nursing facility" defined

In this subchapter, the term ''nursing facility'' means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(*l*) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals

Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the phys-

ical, mental, and psychosocial well-being of each resident;

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers

(i) General requirements

With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) Waiver by State

To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12)[1] of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this subchapter to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

(iii) Assumption of waiver authority by Secretary

If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II) is competent to provide nursing or nursing-related services.

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation,

[1] See References in Text note below.

such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

(E) Regular in-service education

The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term ''nurse aide'' means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

Such term includes an individual who provides such services through an agency or under a contract with the facility.

(G) Licensed health professional defined

In this paragraph, the term ''licensed health professional'' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) Physician supervision and clinical records

A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician);

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any preadmission screening conducted under subsection (e)(7).

(7) Required social services

In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of subchapter XVIII) to a portion of the facility that is such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

(B) Notice of rights

A nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r–5(c)(1)(B) of this title;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6);

(iii) inform each resident who is entitled to medical assistance under this subchapter—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1396a(a)(28)(B) of this title) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1396*o* of this title), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under subchapter XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) Transfer and discharge rights

(A) In general

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this subchapter after admission to the facility, only charges which may be imposed under this subchapter shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a nursing facility must—

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. 15041 et seq.]; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act[1] [42 U.S.C. 10801 et seq.].

(C) Orientation

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) Notice on bed-hold policy and readmission

(i) Notice before transfer

Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

(I) the provisions of the State plan under this subchapter regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer

At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) Permitting resident to return

A nursing facility must establish and follow a written policy under which a resident—

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first avail-

ability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) Information respecting advance directives

A nursing facility must comply with the requirement of section 1396a(w) of this title (relating to maintaining written policies and procedures respecting advance directives).

(F) Continuing rights in case of voluntary withdrawal from participation

(i) In general

In the case of a nursing facility that voluntarily withdraws from participation in a State plan under this subchapter but continues to provide services of the type provided by nursing facilities—

(I) the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day);

(II) the provisions of this section continue to apply to such residents until the date of their discharge from the facility; and

(III) in the case of each individual who begins residence in the facility after the effective date of such withdrawal, the facility shall provide notice orally and in a prominent manner in writing on a separate page at the time the individual begins residence of the information described in clause (ii) and shall obtain from each such individual at such time an acknowledgment of receipt of such information that is in writing, signed by the individual, and separate from other documents signed by such individual.

Nothing in this subparagraph shall be construed as affecting any requirement of a participation agreement that a nursing facility provide advance notice to the State or the Secretary, or both, of its intention to terminate the agreement.

(ii) Information for new residents

The information described in this clause for a resident is the following:

(I) The facility is not participating in the program under this subchapter with respect to that resident.

(II) The facility may transfer or discharge the resident from the facility at such time as the resident is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under this subchapter.

(iii) Continuation of payments and oversight authority

Notwithstanding any other provision of this subchapter, with respect to the residents described in clause (i)(I), a participation agreement of a facility described in clause (i) is deemed to continue in effect under such plan after the effective date of the facility's voluntary withdrawal from participation under the State plan for purposes of—

(I) receiving payments under the State plan for nursing facility services provided to such residents;

(II) maintaining compliance with all applicable requirements of this subchapter; and

(III) continuing to apply the survey, certification, and enforcement authority provided under subsections (g) and (h) (including involuntary termination of a participation agreement deemed continued under this clause).

(iv) No application to new residents

This paragraph (other than subclause (III) of clause (i)) shall not apply to an individual who begins residence in a facility on or after the effective date of the withdrawal from participation under this subparagraph.

(3) Access and visitation rights

A nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

(A) In general

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) Construction

(i) Nothing prohibiting any charges for non-medicaid patients

Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

(ii) No additional services required

Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII, (II) subject to subparagraph (B)(v), not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) Charges for additional services requested

Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term ''nursing facility services''.

(iv) Bona fide contributions

Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(v) Treatment of continuing care retirement communities admission contracts

Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1396r–5 of this title, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.

(6) Protection of resident funds

(A) In general

The nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a noninterest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Notice of certain balances

The facility must notify each resident receiving medical assistance under the

State plan under this subchapter when the amount in the resident's account reaches $200 less than the dollar amount determined under section 1382(a)(3)(B) of this title and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under subchapter XVI.

(iv) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XVIII.

(7) Limitation on charges in case of medicaid-eligible individuals

(A) In general

A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this subchapter, that exceed the payment amounts established by the State for such services under this subchapter.

(B) "Certain medicaid-eligible individual" defined

In subparagraph (A), the term ''certain medicaid-eligible individual'' means an individual who is entitled to medical assistance for nursing facility services in the facility under this subchapter but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this subchapter.

(8) Posting of survey results

A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) Nursing facility administrator

The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

(V)[2] Availability of survey, certification, and complaint investigation reports

A nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) Licensing and Life Safety Code

(A) Licensing

A nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment

A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A nursing facility must operate and provide services in compliance with all applica-

[2] So in original. There are no subpars. (C) to (U).

ble Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards

By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(6) Notice of medicaid rights

Each State, as a condition of approval of its plan under this subchapter, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this subchapter.

(7) State requirements for preadmission screening and resident review

(A) Preadmission screening

(i) In general

Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) Clarification with respect to certain readmissions

The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) Exception for certain hospital discharges

The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for resident review

(i) For mentally ill residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1396d(h) of this title) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) For mentally retarded residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8))—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1396d(d) of this title; and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) Review required upon change in resident's condition

A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

(iv) Prohibition of delegation

A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) Response to preadmission screening and resident review

As of April 1, 1990, the State must meet the following requirements:

(i) Long-term residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

A State shall not be denied payment under this subchapter for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) Other residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retar-

dation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) Residents not requiring nursing facility services and not requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

(II) prepare and orient the resident for such discharge.

(iv) Annual report

Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).

(D) Denial of payment

(i) For failure to conduct preadmission screening or review

No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services

No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) Permitting alternative disposition plans

With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures

Each State, as a condition of approval of its plan under this subchapter, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions

In this paragraph and in subsection (b)(3)(F):

(i) An individual is considered to be ''mentally ill'' if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be ''mentally retarded'' if the individual is mentally retarded or a person with a related condition (as described in section 1396d(d) of this title).

(iii) The term ''specialized services'' has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency eval-

uation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training[3], (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1395i–3(g)(2)(B)(i) of this title or subsection (g)(2)(B)(i); or

(c) has been assessed a civil money penalty described in section 1395i–3(h)(2)(B)(ii) of this title or subsection (h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clauses[4] (i), (iii), or (iv) of subsection (h)(2)(A), clauses[4] (i) or (iii) of section 1395i–3(h)(2)(B) of this title, or section 1395i–3(h)(4) of this title, or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of subchapter XVIII) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

[3] So in original. Probably should be followed by a closing parenthesis.

[4] So in original. Probably should be ''clause''.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) Secretarial standards qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this subchapter and those costs which are to be included in the payment amount under this subchapter for nursing facility services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this subchapter, for purposes of section 1396a(a)(28)(B) of this title, the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review

(A) Minimum criteria

The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) Monitoring compliance

The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) (relating to discharge and placement for active treatment of certain residents).

(9) Criteria for monitoring State waivers

The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii).

(10) Special focus facility program

(A) In general

The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this chapter.

(B) Periodic surveys

Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Annual standard survey

(i) In general

Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) Frequency

(I) In general

Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management

of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) Reduction in administrative costs for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1396b(a)(2)(D) of this title with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the

numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1316 of this title in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1316(a)(1) of this title.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) Investigation of complaints and monitoring nursing facility compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or under subchapter XVIII,

(iii) copies of statements of ownership under section 1320a–3 of this title, and

(iv) information disclosed under section 1320a–5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a nursing facility under paragraphs[5] (1), (2), or (3) of subsection (h), with respect to a nursing facility in the State.

(C) Notice to physicians and nursing facility administrator licensing board

If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(E) Submission of survey and certification information to the Secretary

In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or

[5] So in original. Probably should be ''paragraph''.

terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies

(A) Listing

Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) Deadline and guidance

(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance

If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) Repeated noncompliance

In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(E) Funding

The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1396b(a)(7) of this title, to be necessary for the proper and efficient administration of the State plan.

(F) Incentives for high quality care

In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of section 1396b(a)(7) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter.

(3) Secretarial authority

(A) For State nursing facilities

With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) Other nursing facilities

With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

(I) In general

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties

In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the

imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, and

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(5) Immediate termination of participation for facility where State or Secretary finds noncompliance and immediate jeopardy

If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively[6] shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of sub-

[6] So in original. Probably should be followed by a comma.

sections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV),[7] (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII, including investigations by State medicaid fraud control units.

(i) Nursing Home Compare website

(1) Inclusion of additional information

(A) In general

The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ''Nursing Home Compare'' Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1320a–7j(g) of this title, including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting ''nursing home staff hours per resident day'');

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility

[7] So in original. Cl. (ii) of par. (2)(A) of this subsection does not contain subclauses. Probably means cl. (ii)(IV) of par. (3)(C) of this subsection.

plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1320a–7j(f) of this title, including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside of the facility; and

(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

(B) Deadline for provision of information

(i) In general

Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after March 23, 2010.

(ii) Exception

The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1320a–7j(g) of this title are implemented.

(2) Review and modification of website

(A) In general

The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before March 23, 2010; and

(ii) not later than 1 year after March 23, 2010, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation

In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups;

(iv) skilled nursing facility employees and their representatives; and

(v) any other representatives of programs or groups the Secretary determines appropriate.

(j) Construction

Where requirements or obligations under this section are identical to those provided under section 1395i–3 of this title, the fulfillment of those requirements or obligations under section 1395i–3 of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(k) Funding for State strike teams

In addition to amounts otherwise available, there is appropriated to the Secretary, out of any monies in the Treasury not otherwise appropriated, $250,000,000, to remain available until expended, for purposes of allocating such amount among the States (including the District of Columbia and each territory of the United States) for such a State to establish and implement a strike team that will be deployed to a nursing facility in the State with diagnosed or suspected cases of COVID–19 among residents or staff for the purposes of assisting with clinical care, infection control, or staffing during the emergency period described in section 1320b–5(g)(1)(B) of this title and the 1-year period immediately following the end of such emergency period.

(Aug. 14, 1935, ch. 531, title XIX, § 1919, as added and amended Pub. L. 100–203, title IV, §§ 4211(a)(3), (c), 4212(a), (b), 4213(a), 4216, Dec. 22, 1987, 101 Stat. 1330–182, 1330–196, 1330–207, 1330–213, 1330–220, as amended Pub. L. 100–360, title IV, § 411(*l*)(3)(C)(ii), (6)(B), (8)(A), July 1, 1988, 102 Stat. 803–805; Pub. L. 100–360, title III, § 303(a)(2), title IV, § 411(*l*)(2)(A)–(D), (F)–(K), (L)(ii), (3)(A), (B), (C)(iii), (D), (5), (6)(A), (7), (8)(B), July 1, 1988, 102 Stat. 760, 801–805, as amended Pub. L. 100–485, title VI, § 608(d)(27)(C)–(E), (I), Oct. 13, 1988, 102 Stat. 2423; Pub. L. 101–239, title VI, § 6901(b)(1), (3), (4)(A), (d)(1), (4), Dec. 19, 1989, 103 Stat. 2298–2301; Pub. L. 101–508, title IV, §§ 4751(b)(2), 4801(a)(2)–(6)(A), (7), (b)(2)–(5)(A), (6)–(8), (d)(1), (e)(2)–(7)(A), (8)–(10), (12)–(15), (18), Nov. 5, 1990, 104 Stat. 1388–205, 1388–211 to 1388–219; Pub. L. 102–375, title VII, § 708(a)(1)(B), Sept. 30, 1992, 106 Stat. 1292; Pub. L. 104–315, §§ 1(a), 2(a), (b), Oct. 19, 1996, 110 Stat. 3824; Pub. L. 105–15, § 1, May 15, 1997, 111 Stat. 34; Pub. L. 105–33, title IV, §§ 4754(a), 4755(b), Aug. 5, 1997, 111 Stat. 526; Pub. L. 106–4, § 2(a), Mar. 25, 1999, 113 Stat. 7; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(p)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397; Pub. L. 106–402, title IV, § 401(b)(6)(A), Oct. 30, 2000, 114 Stat. 1738; Pub. L. 106–554, § 1(a)(6) [title IX, § 941(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–586; Pub. L. 108–173, title IX, § 932(c)(2), Dec. 8, 2003, 117 Stat. 2401; Pub. L. 109–171, title VI, § 6015(a), Feb. 8, 2006, 120 Stat. 65; Pub. L. 109–432, div. B, title IV, § 405(c)(2)(B), Dec. 20, 2006, 120 Stat. 3000; Pub. L. 111–148, title VI, §§ 6101(c)(1)(B), 6103(b)(1), (2)(A), (3), (c)(2), 6111(b), 6121(b), Mar. 23, 2010, 124 Stat. 702, 707–709, 715, 721; Pub. L. 117–2, title IX, § 9818, Mar. 11, 2021, 135 Stat. 218.)

Editorial Notes

REFERENCES IN TEXT

The Older Americans Act of 1965, referred to in subsecs. (b)(4)(C)(ii)(IV), (c)(2)(B)(iii)(II), and (g)(5)(B), is Pub. L. 89–73, July 14, 1965, 79 Stat. 218. Section 307(a)(12) of the Act was repealed by Pub. L. 106–501, title III, § 306(5), Nov. 13, 2000, 114 Stat. 2244, and provisions formerly appearing in section 307(a)(12) of the Act are now contained in section 307(a)(9) of the Act, which is classified to section 3027(a)(9) of this title. Titles III

and VII of the Act are classified generally to subchapters III (§ 3021 et seq.) and XI (§ 3058 et seq.), respectively, of chapter 35 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (c)(2)(B)(iii)(III), is Pub. L. 106–402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of the Act probably means subtitle C of title I of the Act, which is classified generally to part C (§ 15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

The Protection and Advocacy for Mentally Ill Individuals Act [of 1986], referred to in subsec. (c)(2)(B)(iii)(IV), was Pub. L. 99–319, May 23, 1986, 100 Stat. 478. Pub. L. 99–319 was renamed the Protection and Advocacy for Individuals with Mental Illness Act by Pub. L. 106–310, div. B, title XXXII, § 3206(a), Oct. 17, 2000, 114 Stat. 1193, and is classified generally to chapter 114 (§ 10801 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10801 of this title and Tables.

Section 6901(b)(4)(B)–(D) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (e)(2)(A), is section 6901(b)(4)(B)–(D) of Pub. L. 101–239, which is set out as a note under section 1395i–3 of this title.

Section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, referred to in subsec. (f)(7)(A), probably means section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95–142, which is set out as a note under section 1395x of this title.

PRIOR PROVISIONS

A prior section 1919 of act Aug. 14, 1935, was renumbered section 1922 and is classified to section 1396r–3 of this title.

AMENDMENTS

2021—Subsec. (k). Pub. L. 117–2 added subsec. (k).

2010—Subsec. (b)(5)(F). Pub. L. 111–148, § 6121(b)(2), inserted concluding provisions.

Subsec. (d)(1)(B), (C). Pub. L. 111–148, § 6101(c)(1)(B), redesignated subpar. (C) as (B) and struck out former subpar. (B) which related to required notice to a State licensing agency of change in ownership, control interest, management, or certain positions of responsibility for a nursing facility.

Subsec. (d)(1)(V). Pub. L. 111–148, § 6103(c)(2), added subpar. (V).

Subsec. (f)(2)(A)(i)(I). Pub. L. 111–148, § 6121(b)(1), inserted '' (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

Subsec. (f)(10). Pub. L. 111–148, § 6103(b)(3), added par. (10).

Subsec. (g)(5)(E). Pub. L. 111–148, § 6103(b)(2)(A), added subpar. (E).

Subsec. (h)(3)(C)(ii). Pub. L. 111–148, § 6111(b)(1), designated existing provisions as subcl. (I), inserted heading, substituted ''Subject to subclause (II), the Secretary'' for ''The Secretary'', and added subcls. (II) to (IV).

Subsec. (h)(8). Pub. L. 111–148, § 6111(b)(2), which directed insertion of ''(ii)(IV),'' after ''(i),'' in subsec. ''(h)(5)(8)'' of this section, was executed to subsec. (h)(8), to reflect the probable intent of Congress. Subsec. (h)(5) does not contain ''(i),''.

Subsecs. (i), (j). Pub. L. 111–148, § 6103(b)(1), added subsec. (i) and redesignated former subsec. (i) as (j).

2006—Subsec. (c)(5)(A)(i)(II). Pub. L. 109–432 substituted ''subparagraph (B)(v)'' for ''clause (v)''.

Pub. L. 109–171, § 6015(a)(1), inserted ''subject to clause (v)'' after ''(II)''.

Subsec. (c)(5)(B)(v). Pub. L. 109–171, § 6015(a)(2), added cl. (v).

2003—Subsec. (f)(2)(B)(iii). Pub. L. 108–173, § 932(c)(2)(A), substituted ''subparagraphs (C) and (D)'' for ''subparagraph (C)'' in introductory provisions.

Subsec. (f)(2)(D). Pub. L. 108–173, § 932(c)(2)(B), added subpar. (D).

2000—Subsec. (b)(8). Pub. L. 106–554 added par. (8).

Subsec. (c)(2)(B)(iii)(III). Pub. L. 106–402 substituted ''subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000'' for ''part C of the Developmental Disabilities Assistance and Bill of Rights Act''.

1999—Subsec. (b)(3)(C)(i)(I). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(p)(1)], struck out ''not later than'' before ''14 days''.

Subsec. (c)(2)(F). Pub. L. 106–4 added subpar. (F).

Subsec. (d)(4)(A). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(p)(2)], inserted closing parenthesis after ''section 1320a–3 of this title''.

1997—Subsec. (f)(2)(B)(iii). Pub. L. 105–15, § 1(1), inserted ''subject to subparagraph (C),'' after ''(iii)''.

Subsec. (f)(2)(C). Pub. L. 105–15, § 1(2), added subpar. (C).

Subsec. (g)(1)(D), (E). Pub. L. 105–33, § 4755(b), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (h)(3)(D). Pub. L. 105–33, § 4754(a), inserted ''and'' at end of cl. (i), substituted a period for '', and'' at end of cl. (ii), and struck out cl. (iii) which read as follows: ''the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.''

1996—Subsec. (b)(3)(E). Pub. L. 104–315, § 2(a), inserted at end ''In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.''

Subsec. (e)(7)(B). Pub. L. 104–315, § 1(a)(1)(A), struck out ''annual'' before ''resident review'' in heading.

Subsec. (e)(7)(B)(iii). Pub. L. 104–315, § 2(b), added cl. (iii).

Pub. L. 104–315, § 1(a)(1)(B), struck out cl. (iii) which related to frequency of reviews as annual, preadmission, and initial.

Subsec. (e)(7)(D)(i). Pub. L. 104–315, § 1(a)(2), struck out ''annual'' before ''review'' in heading.

1992—Subsecs. (c)(2)(B)(iii)(II), (g)(5)(B). Pub. L. 102–375 substituted ''title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act'' for ''section 307(a)(12) of the Older Americans Act of 1965''.

1990—Subsec. (b)(1)(B). Pub. L. 101–508, § 4801(e)(2), inserted at end ''A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.''

Subsec. (b)(3)(C)(i)(I). Pub. L. 101–508, § 4801(e)(3), substituted ''not later than 14 days'' for ''4 days''.

Subsec. (b)(3)(F). Pub. L. 101–508, § 4801(b)(8), substituted ''specialized services'' for ''active treatment'' in cls. (i) and (ii).

Pub. L. 101–508, § 4801(b)(4)(A), inserted at end ''A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).''

Pub. L. 101–508, § 4801(b)(2)(A), substituted ''Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility'' for ''A nursing facility'' in introductory provisions.

Subsec. (b)(4)(A)(vii). Pub. L. 101–508, § 4801(e)(4), added cl. (vii).

Subsec. (b)(4)(C)(ii). Pub. L. 101–508, § 4801(e)(5)(A), substituted ''To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if'' for

''A State may waive the requirement of subclause (I) or (II) of clause (i) with respect to a facility if'' in introductory provisions.

Subsec. (b)(4)(C)(ii)(IV), (V). Pub. L. 101–508, § 4801(e)(5)(B)–(D), which directed amendment of cl. (ii) by adding subcls. (IV) and (V) at the end, was executed by adding subcls. (IV) and (V) after subcl. (III) and before concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(5)(A). Pub. L. 101–508, § 4801(a)(2), designated existing provision as cl. (i), substituted ''Except as provided in clause (ii), a nursing facility'' for ''A nursing facility'' and ''on a full-time basis'' for ''(on a full-time, temporary, per diem, or other basis)'', redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Subsec. (b)(5)(C). Pub. L. 101–508, § 4801(a)(3), substituted ''any State registry established under subsection (e)(2)(A) that the facility believes will include information'' for ''the State registry established under subsection (e)(2)(A) as to information in the registry''.

Subsec. (b)(5)(D). Pub. L. 101–508, § 4801(a)(4), inserted before period at end '', or a new competency evaluation program''.

Subsec. (b)(5)(F)(i). Pub. L. 101–508, § 4801(e)(6), substituted ''(G)) or a registered dietician'' for ''(G))''.

Subsec. (b)(6)(A). Pub. L. 101–508, § 4801(d)(1), inserted before semicolon at end ''(or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)''.

Subsec. (c)(1)(A). Pub. L. 101–508, § 4801(e)(8)(B), inserted at end ''A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.''

Subsec. (c)(1)(A)(iv). Pub. L. 101–508, § 4801(e)(9), inserted before period at end ''and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request''.

Subsec. (c)(1)(A)(x), (xi). Pub. L. 101–508, § 4801(e)(8)(A), added cl. (x) and redesignated former cl. (x) as (xi).

Subsec. (c)(1)(B)(ii). Pub. L. 101–508, § 4801(e)(10), inserted ''including the notice (if any) of the State developed under subsection (e)(6)'' after ''in such rights)''.

Subsec. (c)(2)(E). Pub. L. 101–508, § 4751(b)(2), added subpar. (E).

Subsec. (c)(7), (8). Pub. L. 101–508, § 4801(e)(7)(A), added par. (7) and redesignated former par. (7) as (8).

Subsec. (e)(1)(A). Pub. L. 101–508, § 4801(e)(18), substituted ''under subsection (f)(2)'' for ''under clause (i) or (ii) of subsection (f)(2)(A)''.

Subsec. (e)(2)(A). Pub. L. 101–508, § 4801(e)(12)(A), inserted '', or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989'' after ''in the State''.

Subsec. (e)(2)(C). Pub. L. 101–508, § 4801(e)(12)(B), added subpar. (C).

Subsec. (e)(7)(A). Pub. L. 101–508, § 4801(b)(2)(B), designated existing provision as cl. (i), inserted cl. (i) heading, and added cls. (ii) and (iii).

Subsec. (e)(7)(B)(i)(II), (ii)(II). Pub. L. 101–508, § 4801(b)(8), substituted ''specialized services'' for ''active treatment''.

Subsec. (e)(7)(B)(iv). Pub. L. 101–508, § 4801(b)(4)(B), added cl. (iv).

Subsec. (e)(7)(C)(i) to (iii). Pub. L. 101–508, § 4801(b)(8), substituted ''specialized services'' for ''active treatment'' wherever appearing.

Subsec. (e)(7)(C)(iv). Pub. L. 101–508, § 4801(b)(5)(A), added cl. (iv).

Subsec. (e)(7)(D). Pub. L. 101–508, § 4801(b)(3)(A), struck out ''where failure to conduct preadmission screening'' after ''Denial of payment'' in heading, designated existing provisions as cl. (i), inserted cl. (i) heading, and added cl. (ii).

Subsec. (e)(7)(E). Pub. L. 101–508, § 4801(b)(8), substituted ''specialized services'' for ''active treatment''.

Pub. L. 101–508, § 4801(b)(6), inserted at end ''The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.''

Pub. L. 101–508, § 4801(b)(3)(B), substituted ''the requirements of subparagraphs (A) through (C) of this paragraph'' for ''the requirement of this paragraph''.

Subsec. (e)(7)(G)(i). Pub. L. 101–508, § 4801(b)(7), substituted ''serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)'' for ''primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition)'' and inserted before period at end ''or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness''.

Subsec. (e)(7)(G)(iii). Pub. L. 101–508, § 4801(b)(8), substituted ''specialized services'' for ''active treatment''.

Subsec. (f)(2)(A)(iv)(II). Pub. L. 101–508, § 4801(a)(5)(B), inserted ''who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program'' after ''nurse aide''.

Subsec. (f)(2)(A)(iv)(III). Pub. L. 101–508, § 4801(a)(5)(A), (C), (D), added subcl. (III).

Subsec. (f)(2)(B). Pub. L. 101–508, § 4801(a)(7), inserted ''(through subcontract or otherwise)'' after ''may not delegate'' in last sentence.

Subsec. (f)(2)(B)(iii)(I). Pub. L. 101–508, § 4801(a)(6)(A), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: ''offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d) of this section, within the previous 2 years, or''.

Subsec. (g)(1)(C). Pub. L. 101–508, § 4801(e)(13), inserted at end ''A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.''

Subsec. (g)(5)(A)(i). Pub. L. 101–508, § 4801(e)(14), substituted ''deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans'' for ''deficiencies and plans''.

Subsec. (g)(5)(B). Pub. L. 101–508, § 4801(e)(15), substituted ''or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect'' for ''with respect''.

1989—Subsec. (b)(5)(A). Pub. L. 101–239, § 6901(b)(1)(A), substituted ''October 1, 1990'' for ''January 1, 1990'' in introductory provisions.

Subsec. (b)(5)(B). Pub. L. 101–239, § 6901(b)(1)(B), substituted ''January 1, 1990'' and ''October 1, 1990'' for ''July 1, 1989'' and ''January 1, 1990'', respectively.

Subsec. (c)(1)(A)(ii)(II). Pub. L. 101–239, § 6901(d)(4)(A), substituted ''Secretary until such an order could reasonably be obtained)'' for ''Secretary) until such an order could reasonably be obtained''.

Subsec. (c)(1)(A)(v)(I). Pub. L. 101–239, § 6901(d)(4)(B), substituted ''accommodation'' for ''accommodations''.

Subsec. (f)(2)(A)(i)(I). Pub. L. 101–239, § 6901(d)(4)(C), substituted ''and content of the curriculum'' for '', content of the curriculum''.

Pub. L. 101–239, § 6901(b)(3)(A), inserted ''care of cognitively impaired residents,'' after ''social service needs,''.

Subsec. (f)(2)(A)(ii). Pub. L. 101–239, § 6901(b)(3)(B), substituted ''recognition of mental health and social service needs, care of cognitively impaired residents'' for ''cognitive, behavioral and social care''.

Subsec. (f)(2)(A)(iv). Pub. L. 101–239, § 6901(b)(3)(C), (D), added cl. (iv).

Subsec. (f)(2)(B)(ii). Pub. L. 101–239, § 6901(b)(4)(A), substituted ''July 1, 1989'' for ''January 1, 1989''.

Subsec. (h)(3)(D). Pub. L. 101–239, §6901(d)(4)(D), substituted ''not longer than 6 months after the effective date of the findings'' for ''not longer than 6 months''.

Subsec. (h)(8). Pub. L. 101–239, §6901(d)(1), inserted at end ''The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII.''

1988—Subsec. (b)(3)(A)(iii). Pub. L. 100–360, §411(*l*)(2)(B), struck out ''in the case of a resident eligible for benefits under this subchapter,'' before ''uses an instrument''.

Subsec. (b)(3)(A)(iv). Pub. L. 100–360, §411(*l*)(2)(A), as amended by Pub. L. 100–485, §608(d)(27)(C), struck out ''in the case of a resident eligible for benefits under part A of subchapter XVIII of this chapter,'' before ''includes the identification of medical problems''.

Subsec. (b)(3)(B)(ii)(III). Pub. L. 100–360, §411(*l*)(2)(C), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: ''The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title.''

Subsec. (b)(4)(C)(i)(II). Pub. L. 100–360, §411(*l*)(3)(A)(i), inserted ''professional'' after ''registered''.

Subsec. (b)(4)(C)(ii). Pub. L. 100–360, §411(*l*)(3)(A)(i)–(iv), in heading, substituted ''(ii) Waiver'' for ''(ii) Facility waivers.—(i) Waiver'', in subcl. (III), inserted ''professional'' after ''registered'', and in concluding provisions, substituted ''clause (iii)'' for ''clause (ii)'' and ''use'' for ''employ''.

Subsec. (b)(4)(C)(iii). Pub. L. 100–360, §411(*l*)(3)(A)(v), (vi), substituted ''(iii) Assumption'' for ''(ii) Assumption'' in heading and ''exercise'' for ''excercise'' in text.

Subsec. (b)(5)(A). Pub. L. 100–360, §411(*l*)(3)(B), which directed amendment of subpar. (A) by striking ''subparagraph (E)'' and inserting ''subparagraph (F)'', could not be executed because of prior amendment by Pub. L. 100–360, §411(*l*)(2)(D)(i), see Amendment note below.

Pub. L. 100–360, §411(*l*)(2)(D)(i), as amended by Pub. L. 100–485, §608(d)(27)(D), struck out '', who is not a licensed health professional (as defined in subparagraph (E))'' after ''any individual'' in introductory provisions.

Subsec. (b)(5)(A)(ii). Pub. L. 100–360, §411(*l*)(2)(D)(ii), substituted ''nursing or nursing-related services'' for ''such services''.

Subsec. (b)(5)(G). Pub. L. 100–360, §411(*l*)(2)(D)(iii), inserted ''physical or occupational therapy assistant,'' after ''occupational therapist,''.

Subsec. (c)(1)(B)(i). Pub. L. 100–360, §303(a)(2), inserted before semicolon at end ''and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r–5(c)(1)(B) of this title''.

Subsec. (c)(2)(A)(v). Pub. L. 100–360, §411(*l*)(2)(F), substituted ''for a stay at the facility'' for ''an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this subchapter and subchapter XVIII of this chapter''.

Subsec. (c)(2)(B)(iii)(III). Pub. L. 100–360, §411(*l*)(3)(C)(iii), as added by Pub. L. 100–485, §608(d)(27)(E), substituted ''responsible'' for ''responsibile''.

Subsec. (c)(6). Pub. L. 100–360, §411(*l*)(2)(G), substituted ''upon the written'' for ''once the facility accepts the written'' in subpar. (A)(ii) and ''Upon written'' for ''Upon a facility's acceptance of written'' in subpar. (B).

Subsec. (c)(7). Pub. L. 100–360, §411(*l*)(6)(B), amended Pub. L. 100–203, §4212(b), see 1987 Amendment note below.

Subsec. (e). Pub. L. 100–360, §411(*l*)(3)(C)(ii), as added by Pub. L. 100–485, §608(d)(27)(E), amended Pub. L. 100–203, §4211, see 1987 Amendment note below.

Subsec. (e)(1). Pub. L. 100–360, §411(*l*)(3)(D)(i), (ii), substituted ''January 1, 1989'' for ''September 1, 1988'' in subpar. (A) and ''January'' for ''September'' in subpar. (B).

Subsec. (e)(2)(B). Pub. L. 100–360, §411(*l*)(2)(H), inserted after first sentence ''The State shall make available to the public information in the registry.''

Subsec. (e)(3). Pub. L. 100–360, §411(*l*)(2)(I), inserted ''and discharges'' after ''transfers'' in heading and two places in text.

Subsec. (e)(7)(E). Pub. L. 100–360, §411(*l*)(3)(D)(iii), substituted ''April 1, 1989'' for ''October 1, 1988''.

Subsec. (f). Pub. L. 100–360, §411(*l*)(3)(C)(ii), as added by Pub. L. 100–485, §608(d)(27)(E), amended Pub. L. 100–203, §4211, see 1987 Amendment note below.

Subsec. (f)(2)(A). Pub. L. 100–360, §411(*l*)(3)(D)(iv), substituted ''September'' for ''July'' in introductory provisions.

Subsec. (f)(2)(A)(i)(I). Pub. L. 100–360, §411(*l*)(2)(J), substituted ''recognition of mental health and social service needs'' for ''cognitive, behavioral and social care''.

Subsec. (f)(3). Pub. L. 100–360, §411(*l*)(2)(I), inserted ''and discharges'' after ''transfers'' in heading and in text.

Subsec. (f)(7)(A). Pub. L. 100–360, §411(*l*)(2)(K), substituted ''residents'' for ''patients''.

Subsec. (f)(7)(B). Pub. L. 100–360, §411(*l*)(2)(L)(ii), substituted ''include'' for ''do not include''.

Subsec. (g)(1)(C). Pub. L. 100–360, §411(*l*)(5)(A)–(C), substituted ''and timely review'' for '', review,'', inserted ''or by another individual used by the facility in providing services to such a resident'' after ''a nursing facility'', and substituted ''The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority'' for ''If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding''.

Subsec. (g)(1)(D). Pub. L. 100–360, §411(*l*)(5)(D), substituted ''to issue regulations to carry out this subsection'' for ''to establish standards under subsection (f) of this section''.

Subsec. (g)(2)(A)(i). Pub. L. 100–360, §411(*l*)(5)(E), amended third sentence generally. Prior to amendment, third sentence read as follows: ''The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title.''

Subsec. (g)(2)(B)(ii). Pub. L. 100–360, §411(*l*)(5)(F), as added by Pub. L. 100–485, §608(d)(27)(I), substituted ''practicable'' for ''practical''.

Subsec. (g)(3)(C). Pub. L. 100–360, §411(*l*)(6)(A), redesignated subpar. (C), relating to special surveys of compliance, as (D).

Subsec. (g)(3)(D). Pub. L. 100–360, §411(*l*)(5)(G), formerly §411(*l*)(5)(F), as redesignated by Pub. L. 100–485, §608(d)(27)(I), substituted ''on the basis of that survey'' for ''on that basis''.

Subsec. (g)(4). Pub. L. 100–360, §411(*l*)(5)(H), formerly §411(*l*)(5)(G), as redesignated by Pub. L. 100–485, §608(d)(27)(I), struck out ''chronically'' after ''enforcement actions against'' in last sentence.

Subsec. (h). Pub. L. 100–360, §411(*l*)(8)(A), made technical correction to directory language of Pub. L. 100–203, §4213(a), see 1987 Amendment note below.

Subsec. (h)(1). Pub. L. 100–360, §411(*l*)(8)(B)(i), substituted ''paragraph (2)(A)(ii)''for ''paragraph (2)(A)(i)'' in last sentence.

Subsec. (h)(2)(B)(i). Pub. L. 100–360, § 411(*l*)(8)(B)(ii), struck out ''or otherwise'' after ''regulations''.

Subsec. (h)(3)(C)(ii). Pub. L. 100–360, § 411(*l*)(7)(A), substituted ''. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title'' for ''and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1320a–7a of this title''.

Subsec. (h)(5). Pub. L. 100–360, § 411(*l*)(8)(B)(iii), substituted ''State or the Secretary, respectively'' for ''State and the Secretary''.

Subsec. (h)(9). Pub. L. 100–360, § 411(*l*)(7)(B), inserted ''by such facilities'' after ''be made available''.

1987—Subsec. (c)(7). Pub. L. 100–203, § 4212(b), as amended by Pub. L. 100–360, § 411(*l*)(6)(B), added par. (7).

Subsecs. (e), (f). Pub. L. 100–203, § 4211, which contained two subsecs. (c), the first of which amended this section and the second of which enacted provisions set out as a note below, was amended by Pub. L. 100–360, § 411(*l*)(3)(C)(ii), to delete the designation, heading, and directory language of the first subsec. (c), resulting in subsecs. (e) and (f) being added by section 4211(a)(3) of Pub. L. 100–203, which enacted subsecs. (a) to (d) of this section.

Subsec. (g). Pub. L. 100–203, § 4212(a), added subsec. (g).

Subsec. (h). Pub. L. 100–203, § 4213(a), as amended by Pub. L. 100–360, § 411(*l*)(8)(A), added subsec. (h).

Subsec. (i). Pub. L. 100–203, § 4216, added subsec. (i).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6101(c)(1)(B) of Pub. L. 111–148 effective on the date on which the Secretary of Health and Human Services makes the information described in section 6101(b) of Pub. L. 111–148, set out as a note under section 1320a–3 of this title, available to the public, see section 6101(c)(2) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

Pub. L. 111–148, title VI, § 6103(b)(2)(B), Mar. 23, 2010, 124 Stat. 709, provided that: ''The amendment made by this paragraph [amending this section] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].''

Amendment by section 6103(c)(2) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6103(c)(3) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

Amendment by section 6111(b) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6111(c) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

Amendment by section 6121(b) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6121(c) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, § 405(c)(2)(B), Dec. 20, 2006, 120 Stat. 3000, provided that the amendment made by section 405(c)(2)(B) is effective as if included in the amendment made by section 6015(a)(1) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to appeals filed on or after Oct. 1, 2004, see section 932(d) of Pub. L. 108–173, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective Jan. 1, 2003, see section 1(a)(6) [title IX, § 941(c)] of Pub. L. 106–554, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–4, § 2(b), Mar. 25, 1999, 113 Stat. 8, provided that: ''The amendment made by subsection (a) [amending this section] applies to voluntary withdrawals from participation occurring on or after the date of the enactment of this Act [Mar. 25, 1999].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4754(b), Aug. 5, 1997, 111 Stat. 526, provided that: ''The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Aug. 5, 1997].''

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–315, § 1(b), Oct. 19, 1996, 110 Stat. 3824, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 19, 1996].''

Pub. L. 104–315, § 2(c), Oct. 19, 1996, 110 Stat. 3825, provided that: ''The amendments made by this section [amending this section] shall apply to changes in physical or mental condition occurring on or after the date of the enactment of this Act [Oct. 19, 1996].''

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1993, see section 4(b) of Pub. L. 103–171, set out as a note under section 3001 of this title.

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1992, see section 905(b)(6) of Pub. L. 102–375, set out as a note under section 3001 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4751(b)(2) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4751(c) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, § 4801(a)(6)(B), Nov. 5, 1990, 104 Stat. 1388–212, provided that: ''The amendments made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203], except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

''(i) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.];

''(ii) was subject to a denial of payment under either such title;

''(iii) was assessed a civil money penalty not less than $5,000 for deficiencies in nursing facility standards;

''(iv) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

''(v) pursuant to State action, was closed or had its residents transferred.''

Amendment by section 4801(a)(2)–(5), (7) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4801(a)(9) of Pub. L. 101–508, set out as a note under section 1396b of this title.

Pub. L. 101–508, title IV, § 4801(b)(9), Nov. 5, 1990, 104 Stat. 1388–215, provided that:

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].

''(B) EXCEPTION.—The amendments made by paragraphs (4), (6), and (8) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], without regard to whether or not regulations to implement such amendments have been promulgated.''

Pub. L. 101–508, title IV, § 4801(d)(2), Nov. 5, 1990, 104 Stat. 1388–215, provided that: ''The amendment made by paragraph (1) [amending this section] applies with respect to nursing facility services furnished on or after October 1, 1990, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.''

Pub. L. 101–508, title IV, § 4801(e)(7)(B), Nov. 5, 1990, 104 Stat. 1388–217, provided that: ''The amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], without regard to whether or not regulations to implement such amendments have been promulgated.''

Amendment by section 4801(e)(2)–(6), (8)–(10), (12)–(15), and (18) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4801(e)(19) of Pub. L. 101–508, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6901(b)(1), (4)(A) of Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, and amendment by section 6901(b)(3) of Pub. L. 101–239 applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after end of 90-day period beginning on Dec. 19, 1989, but not to affect competency evaluations conducted under programs offered before end of that period, see section 6901(b)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

Amendment by section 6901(d)(1) of Pub. L. 101–239 effective Dec. 19, 1989, and amendment by section 6901(d)(4) of Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 6901(d)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by 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 303(a)(2) of Pub. L. 100–360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Sept. 30, 1989, without regard to whether or not final regulations to carry out such amendment has been promulgated by such date, see section 303(g)(1)(A), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(*l*)(2)(A)–(D), (F)–(K), (L)(ii), (3)(A), (B), (C)(ii), (iii), (D), (5), (6)(A), (B), (7), and (8)(A), (B) 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.

EFFECTIVE DATE

Pub. L. 100–203, title IV, § 4214, Dec. 22, 1987, 101 Stat. 1330–219, as amended by Pub. L. 100–360, title IV, § 411(*l*)(10), July 1, 1988, 102 Stat. 806, provided that:

''(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1919 of the Social Security Act [42 U.S.C. 1396r], the amendments made by sections 4211 [enacting this section, amending sections 1320a–7b, 1396a, 1396b, 1396d, 1396j, 1396*l*, 1396n, 1396*o*, 1396p, 1396r, and 1396s of this title, redesignating section 1396r of this title as section 1396r–3 of this title, and amending provisions set out as a note under section 1396r–3 of this title] and 4212 [amending sections 1395cc, 1396a, 1396b, 1396i, and 1396r of this title] (relating to nursing facility requirements and survey and certification requirements) shall apply to nursing facility services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date; except that section 1902(a)(28)(B) of the Social Security Act [42 U.S.C. 1396a(a)(28)(B)] (as amended by section 4211(b) of this Act), relating to requiring State medical assistance plans to specify the services included in nursing facility services, shall apply to calendar quarters beginning more than 6 months after the date of the enactment of this Act [Dec. 22, 1987], without regard to whether regulations to implement such section are promulgated by such date.

''(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1919 of the Social Security Act [42 U.S.C. 1396r], the amendments made by section 4213 of this Act [amending this section and sections 1396a and 1396b of this title] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after the date of the enactment of this Act [Dec. 22, 1987], without regard to whether regulations to implement such amendments are promulgated by such date.

''(2) In applying the amendments made by this part [part 2 of subtitle C (§§ 4211–4218) of title IV of Pub. L. 100–203, see Tables for classification] for services furnished before October 1, 1990—

''(A) any reference to a nursing facility is deemed a reference to a skilled nursing facility or intermediate care facility (other than an intermediate care facility for the mentally retarded), and

''(B) with respect to such a skilled nursing facility or intermediate care facility, any reference to a requirement of subsection (b), (c), or (d) of section 1919 of the Social Security Act [42 U.S.C. 1396r(b), (c), (d)], is deemed a reference to the provisions of section 1861(j) or section 1905(c), respectively, of the Social Security Act [42 U.S.C. 1395x(j), 1396d(c)].

''(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this part and implementing the amendments made by this part.''

RETROACTIVE REVIEW

For requirement that procedures developed by a State permit individual to petition for review of any finding made by a State under subsec. (g)(1)(C) of this section or section 1395i–3(g)(1)(C) of this title after Jan. 1, 1995, see section 4755(c) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; COMPLIANCE ACTIONS

Pub. L. 101–508, title IV, § 4801(a)(1), Nov. 5, 1990, 104 Stat. 1388–211, provided that: ''The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act [42 U.S.C. 1396c] on the basis of the State's failure to meet the requirement of section 1919(e)(1)(A) of such Act [42 U.S.C. 1396r(e)(1)(A)] before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1919(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.''

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW; COMPLIANCE ACTIONS

Pub. L. 101–508, title IV, § 4801(b)(1), Nov. 5, 1990, 104 Stat. 1388–213, provided that: ''The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 or section 1919(e)(7)(D) of the Social Security Act [42 U.S.C. 1396c, 1396r(e)(7)(D)] on the basis of the State's failure to meet the requirement of section 1919(e)(7)(A)

of such Act before the effective date of guidelines, issued by the Secretary, establishing minimum criteria under section 1919(f)(8)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.''

RESTRICTION ON ENFORCEMENT PROCESS

Pub. L. 101–508, title IV, § 4801(c), Nov. 5, 1990, 104 Stat. 1388–215, provided that: ''The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act [42 U.S.C. 1396c] on the basis of the State's failure to meet the requirements of section 1919(h)(2) of such Act [42 U.S.C. 1396r(h)(2)] before the effective date of guidelines, issued by the Secretary, regarding the establishment of remedies by the State under such section, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirements before such effective date.''

STAFFING REQUIREMENTS

Pub. L. 101–508, title IV, § 4801(e)(17), Nov. 5, 1990, 104 Stat. 1388–218, as amended by Pub. L. 105–362, title VI, § 602(b)(1), Nov. 10, 1998, 112 Stat. 3286, provided that:

''(A) MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 [Dec. 22, 1987] with respect to services described in clauses (ii), (iv), and (v) of section 1919(b)(4)(A) of the Social Security Act [42 U.S.C. 1396r(b)(4)(A)(ii), (iv), (v)] shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

''(B) STUDY ON STAFFING REQUIREMENTS IN NURSING FACILITIES.—The Secretary shall conduct a study and report to Congress no later than January 1, 1999, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for skilled nursing facilities serving as providers of services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and nursing facilities receiving payments under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], and shall include in such study recommendations regarding appropriate minimum ratios.''

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; SATISFACTION OF REQUIREMENTS; WAIVER

For satisfaction of training and competency evaluation requirements of subsec. (b)(5)(A) of this section and section 1395i–3(b)(5)(A) of this title and authorization for a State to waive such competency evaluation requirements, see section 6901(b)(4)(B)–(D) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

PUBLICATION OF PROPOSED REGULATIONS RESPECTING PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

Pub. L. 101–239, title VI, § 6901(c), Dec. 19, 1989, 103 Stat. 2300, provided that: ''The Secretary of Health and Human Services shall issue proposed regulations to establish the criteria described in section 1919(f)(8)(A) of the Social Security Act [42 U.S.C. 1396r(f)(8)(A)] by not later than 90 days after the date of the enactment of this Act [Dec. 19, 1989].''

EVALUATION AND REPORT ON IMPLEMENTATION OF RESIDENT ASSESSMENT PROCESS

Pub. L. 100–203, title IV, § 4211(c), Dec. 22, 1987, 101 Stat. 1330–196, directed Secretary of Health and Human Services to evaluate and report to Congress by not later than Jan. 1, 1993, on implementation of resident assessment process for residents of nursing facilities under amendments made by section 4211(c).

REPORT ON STAFFING REQUIREMENTS

Pub. L. 100–203, title IV, § 4211(k), Dec. 22, 1987, 101 Stat. 1330–207, directed Secretary of Health and Human Services to report to Congress, by not later than Jan. 1, 1993, on progress made in implementing the nursing facility staffing requirements of 42 U.S.C. 1396r(b)(4)(C), including the number and types of waivers approved under subparagraph (C)(ii) of such section and the number of facilities which received waivers.

ANNUAL REPORT ON STATUTORY COMPLIANCE AND ENFORCEMENT ACTIONS

Pub. L. 100–203, title IV, § 4215, Dec. 22, 1987, 101 Stat. 1330–220, as amended by Pub. L. 101–508, title IV, § 4801(b)(5)(B), Nov. 5, 1990, 104 Stat. 1388–214, provided that: ''The Secretary of Health and Human Services shall report to the Congress annually on the extent to which nursing facilities are complying with the requirements of subsections (b), (c), and (d) of section 1919 of the Social Security Act [42 U.S.C. 1396r(b), (c), (d)] (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1919(h) of such Act (as added by section 4213 of this Act). Each such report shall also include a summary of the information reported by States under section 1919(e)(7)(C)(iv) of such Act.''

§ 1396r–1. Presumptive eligibility for pregnant women

(a) Ambulatory prenatal care

A State plan approved under section 1396a of this title may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) Definitions

For purposes of this section—

(1) the term ''presumptive eligibility period'' means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and

(2) the term ''qualified provider'' means any provider that—

(A) is eligible for payments under a State plan approved under this subchapter,

(B) provides services of the type described in subparagraph (A) or (B) of section 1396d(a)(2) of this title or in section 1396d(a)(9) of this title,

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under—

(I) section 254b or 254c of this title,

(II) subchapter V of this chapter, or

(III) title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.];

(ii) participates in a program established under—

(I) section 1786 of this title, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973;

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a 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. 5321 et seq.].

The term ''qualified provider'' also includes a qualified entity, as defined in section 1396r–1a(b)(3) of this title.

(c) Duties of State agency, qualified providers, and presumptively eligible pregnant women

(1) The State agency shall provide qualified providers with—

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by not later than the last day of the month following the month during which the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1396a(*l*)(1)(A) of this title.

(d) Ambulatory prenatal care as medical assistance

Notwithstanding any other provision of this subchapter, ambulatory prenatal care that—

(1) is furnished to a pregnant woman—

(A) during a presumptive eligibility period,

(B) by a provider that is eligible for payments under the State plan; and

(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1396b of this title.

(e) Option to provide presumptive eligibility

If the State has elected the option to provide a presumptive eligibility period under this section or section 1396r–1a of this title, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII), clause (i)(IX), or clause (ii)(XX) of subsection (a)(10)(A)[1] or section 1396u–1 of this title in the same manner as the State provides for such a period under this section or section 1396r–1a of this title, subject to such guidance as the Secretary shall establish.

(Aug. 14, 1935, ch. 531, title XIX, §1920, as added Pub. L. 99–509, title IX, §9407(b), Oct. 21, 1986, 100 Stat. 2058; amended Pub. L. 100–360, title IV, §411(k)(16)(A), (B), July 1, 1988, 102 Stat. 799; Pub. L. 100–485, title VI, §608(d)(26)(L), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 101–508, title IV, §4605(a), (b), Nov. 5, 1990, 104 Stat. 1388–169; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(q)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397; Pub. L. 111–3, title I, §113(b)(2), Feb. 4, 2009, 123 Stat. 34; Pub. L. 111–148, title II, §§2001(a)(4)(B), (e)(2)(C), 2004(b), Mar. 23, 2010, 124 Stat. 274, 279, 283.)

Editorial Notes

REFERENCES IN TEXT

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

Section 4(a) of the Agriculture and Consumer Protection Act of 1973, referred to in subsec. (b)(2)(D)(ii)(II), is section 4(a) of Pub. L. 93–86, Aug. 10, 1973, 87 Stat. 249, which is set out as a note under section 612c of Title 7, Agriculture.

The Indian Self-Determination Act (Public Law 93–638), referred to in subsec. (b)(2)(D)(iv), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

PRIOR PROVISIONS

A prior section 1920 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2010—Subsec. (e). Pub. L. 111–148, §2004(b), inserted '', clause (i)(IX),'' after ''clause (i)(VIII)''.

Pub. L. 111–148, §2001(e)(2)(C), inserted ''or clause (ii)(XX)'' after ''clause (i)(VIII)''.

Pub. L. 111–148, §2001(a)(4)(B), added subsec. (e).

2009—Subsec. (b). Pub. L. 111–3 inserted concluding provisions.

1999—Subsec. (b)(2)(D)(i)(I). Pub. L. 106–113 substituted ''section 254b or 254c of this title,'' for ''section 254b, 254c, or 256 of this title,''.

1990—Subsec. (b)(1)(B). Pub. L. 101–508, §4605(a)(1), inserted ''or'' at end of cl. (i), redesignated cl. (iii) as (ii) and amended it generally, and struck out former cl. (ii). Prior to amendment, cls. (ii) and (iii) read as follows:

''(ii) the day that is 45 days after the date on which the provider makes the determination referred to in subparagraph (A), or

''(iii) in the case of a woman who does not file an application for medical assistance within 14 calendar days

[1] So in original. Probably means subsection (a)(10)(A) of section 1396a of this title.

after the date on which the provider makes the determination referred to in subparagraph (A), the fourteenth calendar day after such determination is made; and''.

Subsec. (c)(2)(B). Pub. L. 101–508, § 4605(a)(2), substituted ''by not later than the last day of the month following the month during which'' for ''within 14 calendar days after the date on which''.

Subsec. (c)(3). Pub. L. 101–508, § 4605(b), inserted before period at end '', which application may be the application used for the receipt of medical assistance by individuals described in section 1396a(*l*)(1)(A) of this title''.

Pub. L. 101–508, § 4605(a)(2), substituted ''by not later than the last day of the month following the month during which'' for ''within 14 calendar days after the date on which''.

1988—Subsec. (b)(2)(D)(i). Pub. L. 100–360, § 411(k)(16)(B)(i), substituted ''section 254b, 254c, or 256 of this title,'' for ''section 254b of this title or section 254c of this title, or'' in subcl. (I), substituted ''chapter, or'' for ''chapter;'' in subcl. (II), and added subcl. (III).

Subsec. (b)(2)(D)(ii)(II). Pub. L. 100–360, § 411(k)(16)(B)(ii), as amended by Pub. L. 100–485, § 608(d)(26)(L)(i), struck out ''or'' after ''1973;''.

Subsec. (b)(2)(D)(iii). Pub. L. 100–360, § 411(k)(16)(B)(iii), as added by Pub. L. 100–485, § 608(d)(26)(L)(iii), substituted ''program; or'' for ''program.''

Subsec. (b)(2)(D)(iv). Pub. L. 100–360, § 411(k)(16)(B)(iv), formerly § 411(k)(16)(B)(iii), as redesignated by Pub. L. 100–485, § 608(d)(26)(L)(ii), added cl. (iv).

Subsec. (d)(1)(B). Pub. L. 100–360, § 411(k)(16)(A), substituted ''by a provider that is eligible for payments under the State plan'' for ''by a qualified provider''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2004(b) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4605(c), Nov. 5, 1990, 104 Stat. 1388–169, provided that:

''(1) The amendments made by subsection (a) [amending this section] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2) The amendment made by subsection (b) [amending this section] shall be effective as if included in the enactment of section 9407(b) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509, enacting this section].''

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by 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.

Pub. L. 100–360, title IV, § 411(k)(16)(C), July 1, 1988, 102 Stat. 799, provided that: ''The amendments made by this paragraph [amending this section] shall be effective as if they were included in section 9407(b) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

EFFECTIVE DATE

Section applicable to ambulatory prenatal care furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether or not final regulations to carry out such section have been promulgated, see section 9407(d) of Pub. L. 99–509, set out as an Effective Date of 1986 Amendment note under section 1396a of this title.

§ 1396r–1a. Presumptive eligibility for children

(a) In general

A State plan approved under section 1396a of this title may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

(b) Definitions; regulations

For purposes of this section:

(1) The term ''child'' means an individual under 19 years of age.

(2) The term ''presumptive eligibility period'' means, with respect to a child, the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(3)(A) Subject to subparagraph (B), the term ''qualified entity'' means any entity that—

(i)(I) is eligible for payments under a State plan approved under this subchapter and provides items and services described in subsection (a), (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9831 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.], eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 1786 of this title[1] eligibility of a child for medical assistance under the State plan under this subchapter, or eligibility of a child for child health assistance under the program funded under subchapter XXI, (III) is an elementary school or secondary school, as such terms are defined in section 8801 of title 20,[2] an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, an organization that is providing emergency food and shelter under

[1] So in original. A comma probably should appear after ''title''.

[2] See References in Text note below.

a grant under the Stewart B. McKinney Homeless Assistance Act[2] [42 U.S.C. 11301 et seq.], or a State or tribal office or entity involved in enrollment in the program under this subchapter, under part A of subchapter IV, under subchapter XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 [42 U.S.C. 1437f] or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (2).

(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Application for medical assistance; procedure upon determination of presumptive eligibility

(1) The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

(2) A qualified entity that determines under subsection (b)(2) that a child is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1396a(*l*)(1) of this title.

(d) Treatment of medical assistance

Notwithstanding any other provision of this subchapter, medical assistance for items and services described in subsection (a) that—

(1) are furnished to a child—

(A) during a presumptive eligibility period,

(B) by an entity that is eligible for payments under the State plan; and

(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1396b of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1920A, as added Pub. L. 105–33, title IV, § 4912(a), Aug. 5, 1997, 111 Stat. 571; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(r)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397; Pub. L. 106–554, § 1(a)(6) [title VII, § 708], Dec. 21, 2000, 114 Stat. 2763, 2763A–577.)

Editorial Notes

REFERENCES IN TEXT

The Head Start Act, referred to in subsec. (b)(3)(A)(i)(II), is subchapter B (§§ 635–657) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§ 9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (b)(3)(A)(i)(II), is subchapter C (§ 658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, as added by Pub. L. 101–508, title V, § 5082(2), Nov. 5, 1990, 104 Stat. 1388–236, which is classified generally to subchapter II–B (§ 9857 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see section 9857(a) of this title and Tables.

Section 8801 of title 20, referred to in subsec. (b)(3)(A)(i)(III), was repealed by Pub. L. 107–110, title X, § 1011(5)(C), Jan. 8, 2002, 115 Stat. 1986. See section 7801 of Title 20, Education.

The Stewart B. McKinney Homeless Assistance Act, referred to in subsec. (b)(3)(A)(i)(III), was Pub. L. 100–77, July 22, 1987, 101 Stat. 482. Pub. L. 100–77 was renamed the McKinney-Vento Homeless Assistance Act by Pub. L. 106–400, § 1, Oct. 30, 2000, 114 Stat. 1675, and is classified principally to chapter 119 (§ 11301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11301 of this title and Tables.

The United States Housing Act of 1937, referred to in subsec. (b)(3)(A)(i)(III), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93–383, title II, § 201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§ 1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The Native American Housing Assistance and Self-Determination Act of 1996, referred to in subsec. (b)(3)(A)(i)(III), is Pub. L. 104–330, Oct. 26, 1996, 110 Stat. 4016, which is classified principally to chapter 43 (§ 4101 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 4101 of Title 25 and Tables.

AMENDMENTS

2000—Subsec. (b)(3)(A)(i). Pub. L. 106–554, § 1(a)(6) [title VII, § 708(b)(1)], substituted ''42 U.S.C. 9831'' for ''42 U.S.C. 9821''.

Pub. L. 106–554, § 1(a)(6) [title VII, § 708(a)(2)], inserted before semicolon ''eligibility of a child for medical assistance under the State plan under this subchapter, or eligibility of a child for child health assistance under the program funded under subchapter XXI, (III) is an elementary school or secondary school, as such terms are defined in section 8801 of title 20, an elementary or secondary school operated or supported by the Bureau

of Indian Affairs, a State or tribal child support enforcement agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this subchapter, under part A of subchapter IV, under subchapter XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary''.

Pub. L. 106–554, §1(a)(6) [title VII, §708(a)(1)], substituted '', (II)'' for ''or (II)''.

Subsec. (b)(3)(A)(ii). Pub. L. 106–554, §1(a)(6) [title VII, §708(b)(2)], substituted ''paragraph (2)'' for ''paragraph (1)(A)''.

Subsec. (c)(2). Pub. L. 106–554, §1(a)(6) [title VII, §708(b)(3)], substituted ''subsection (b)(2)'' for ''subsection (b)(1)(A)'' in introductory provisions.

1999—Subsec. (d)(1)(B). Pub. L. 106–113 substituted ''an entity'' for ''a entity''.

§ 1396r–1b. Presumptive eligibility for certain breast or cervical cancer patients

(a) State option

A State plan approved under section 1396a of this title may provide for making medical assistance available to an individual described in section 1396a(aa) of this title (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

(b) Definitions

For purposes of this section:

(1) Presumptive eligibility period

The term ''presumptive eligibility period'' means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1396a(aa) of this title; and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term ''qualified entity'' means any entity that—

(i) is eligible for payments under a State plan approved under this subchapter; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Regulations

The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Administration

(1) In general

The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of this subchapter, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period;

(B) by a[1] entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1396d(b) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1920B, as added Pub. L. 106–354, §2(b)(1), Oct. 24, 2000, 114 Stat. 1382.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, without

[1] So in original. Probably should be ''an''.

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 an Effective Date of 2000 Amendment note under section 1396a of this title.

§ 1396r–1c. Presumptive eligibility for family planning services

(a) State option

State[1] plan approved under section 1396a of this title may provide for making medical assistance available to an individual described in section 1396a(ii) of this title (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1396a(ii) of this title, such medical assistance shall be limited to family planning services and supplies described in 1396d(a)(4)(C)[2] of this title and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

(b) Definitions

For purposes of this section:

(1) Presumptive eligibility period

The term ''presumptive eligibility period'' means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1396a(ii) of this title; and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term ''qualified entity'' means any entity that—

(i) is eligible for payments under a State plan approved under this subchapter; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

(c) Administration

(1) In general

The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of law, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period; and

(B) by a[3] entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1396d(b) of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1920C, as added Pub. L. 111–148, title II, § 2303(b)(1), Mar. 23, 2010, 124 Stat. 294.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section 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.

§ 1396r–2. Information concerning sanctions taken by State licensing authorities against health care practitioners and providers

(a) Information reporting requirement

The requirement referred to in section 1396a(a)(49) of this title is that the State must provide for the following:

[1] So in original. Probably should be preceded by ''A''.

[2] So in original. Probably should be preceded by ''section''.

[3] So in original. Probably should be ''an''.

(1) Information reporting system

(A) Licensing or certification actions

The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:

(i) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(ii) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(iii) Any other loss of license or the right to apply for, or renew, a license by the practitioner or entity, whether by operation of law, voluntary surrender, nonrenewability, or otherwise.

(iv) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.

(B) Other final adverse actions

The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency.

(2) Access to documents

The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of a State licensing or certification agency or State law or fraud enforcement agency as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this chapter.

(b) Form of information

The information described in subsection (a)(1) shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this chapter and in order to provide, directly or through suitable arrangements made by the Secretary, information—

(1) to agencies administering Federal health care programs, including private entities administering such programs under contract,

(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;[1]

(3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1320a–7(h) of this title),

(4) to utilization and quality control peer review organizations[2] described in part B of subchapter XI and to appropriate entities with contracts under section 1320c–3(a)(4)(C)[3] of this title with respect to eligible organizations reviewed under the contracts, but only with respect to information provided pursuant to subsection (a)(1)(A),

(5) to State law or fraud enforcement agencies,

(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986 [42 U.S.C. 11151]), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 [42 U.S.C. 11137] of, and be subject to the provisions of, that Act [42 U.S.C. 11101 et seq.]), but only with respect to information provided pursuant to subsection (a)(1)(A),

(7) to health plans (as defined in section 1320a–7c(c) of this title);[1]

(8) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and

(9) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) Confidentiality of information provided

The Secretary shall provide for suitable safeguards for the confidentiality of the information furnished under subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(d) Disclosure and correction of information

(1) Disclosure

With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

(2) Corrections

Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already

[1] So in original. The semicolon probably should be a comma.

[2] So in original. Probably should be ''to quality improvement organizations''.

[3] See References in Text note below.

reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

(e) Fees for disclosure

The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

(f) Protection from liability for reporting

No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

(g) References

For purposes of this section:

(1) State licensing or certification agency

The term ''State licensing or certification agency'' includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

(2) State law or fraud enforcement agency

The term ''State law or fraud enforcement agency'' includes—

(A) a State law enforcement agency; and

(B) a State medicaid fraud control unit (as defined in section 1396b(q) of this title).

(3) Final adverse action

(A) In general

Subject to subparagraph (B), the term ''final adverse action'' includes—

(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

(ii) State criminal convictions related to the delivery of a health care item or service;

(iii) exclusion from participation in State health care programs (as defined in section 1320a–7(h) of this title);

(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) Exception

Such term does not include any action with respect to a malpractice claim.

(h) Appropriate coordination

In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1320a–7e of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1921, as added Pub. L. 100–93, §5(b), Aug. 18, 1987, 101 Stat. 690; amended Pub. L. 101–508, title IV, §4752(f)(1), Nov. 5, 1990, 104 Stat. 1388–208; Pub. L. 111–148, title VI, §6403(b), Mar. 23, 2010, 124 Stat. 764.)

Editorial Notes

REFERENCES IN TEXT

Section 1320c–3(a)(4)(C) of this title, referred to in subsec. (b)(4), was repealed by Pub. L. 112–40, title II, §261(c)(2)(A)(ii), Oct. 21, 2011, 125 Stat. 425.

The Health Care Quality Improvement Act of 1986 and that Act, referred to in subsecs. (b)(6) and (h), are title IV of Pub. L. 99–660, Nov. 14, 1986, 100 Stat. 3784, which is classified generally to chapter 117 (§11101 et seq.) of this title. Part B of the Act is classified generally to subchapter II (§11131 et seq.) of chapter 117 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11101 of this title and Tables.

PRIOR PROVISIONS

A prior section 1921 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, §6403(b)(1)(A)(ii), redesignated subpars. (A) to (D) as cls. (i) to (iv), respectively, of subpar. (A).

Pub. L. 111–148, §6403(b)(1)(A)(i), which directed adding subpar. (A) and striking out ''The State'' and all that follows through the ''semicolon'', was executed by adding subpar. (A) and striking out ''The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities:'', to reflect the probable intent of Congress.

Subsec. (a)(1)(A)(iii). Pub. L. 111–148, §6403(b)(1)(A)(iii), substituted ''license or the right to apply for, or renew, a license by'' for ''the license of'' and inserted ''nonrenewability,'' after ''voluntary surrender,''.

Subsec. (a)(1)(B). Pub. L. 111–148, §6403(b)(1)(A)(iv), added subpar. (B).

Subsec. (a)(2). Pub. L. 111–148, §6403(b)(1)(B), substituted ''a State licensing or certification agency or State law or fraud enforcement agency'' for ''the authority described in paragraph (1)''.

Subsec. (b)(2). Pub. L. 111–148, §6403(b)(2)(A), added par. (2) and struck out former par. (2) which read as follows: ''to licensing authorities described in subsection (a)(1) of this section,''.

Subsec. (b)(4). Pub. L. 111–148, §6403(b)(2)(B), inserted '', but only with respect to information provided pursuant to subsection (a)(1)(A)'' before comma at end.

Subsec. (b)(5). Pub. L. 111–148, §6403(b)(2)(C), added par. (5) and struck out former par. (5) which read as follows: ''to State medicaid fraud control units (as defined in section 1396b(q) of this title),''.

Subsec. (b)(6). Pub. L. 111–148, §6403(b)(2)(B), inserted '', but only with respect to information provided pursuant to subsection (a)(1)(A)'' before comma at end.

Subsec. (b)(7) to (9). Pub. L. 111–148, §6403(b)(2)(D), (E), added par. (7) and redesignated former pars. (7) and (8) as (8) and (9), respectively.

Subsecs. (d) to (g). Pub. L. 111–148, §6403(b)(3), added subsecs. (d) to (g). Former subsec. (d) redesignated (h).

Subsec. (h). Pub. L. 111–148, §6403(b)(3), (4), redesignated subsec. (d) as (h) and substituted ''In implementing this section, the Secretary shall provide for

the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1320a–7e of this title.'' for ''The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986.''

1990—Subsec. (a)(1). Pub. L. 101–508, § 4752(f)(1)(A), inserted ''(or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)'' after ''health care practitioners'' in introductory provisions.

Subsec. (a)(1)(D). Pub. L. 101–508, § 4752(f)(1)(B), added subpar. (D).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective on the first day after the final day of the transition period defined in section 6403(d)(5) of Pub. L. 111–148, see section 6403(d)(6) of Pub. L. 111–148, set out as a Transition Process; Regulations; Effective Date of 2010 Amendment note under section 1320a–7e of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4752(f)(2), Nov. 5, 1990, 104 Stat. 1388– 208, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary of Health and Human Services has promulgated any regulations to carry out such amendments by such date.''

EFFECTIVE DATE

Section applicable, with certain exceptions, to payments under subchapter XIX of this chapter for calendar quarters beginning more than thirty days after Aug. 18, 1987, without regard to whether or not final regulations to carry out this section have been published by that date, see section 15(c)(1), (2) of Pub. L. 100–93 set out as an Effective Date of 1987 Amendment note under section 1320a–7 of this title.

§ 1396r–3. Correction and reduction plans for intermediate care facilities for mentally retarded

(a) Written plans to remedy substantial deficiencies; time for submission

If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment), the State may elect, subject to the limitations in this section, to—

(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a ''reduction plan'').

(b) Conditions for approval of reduction plans

As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

(c) Contents of reduction plan

The reduction plan must—

(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a)) was made; and

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

(d) Notice and comment; approval of more than 15 reduction plans in any fiscal year; corrections costing $2,000,000 or more

(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are $2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

(e) Termination of provider agreements; disallowance of percentage amounts for purposes of Federal financial participation

(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility's provider agreement in accordance with the provisions of section 1396i(b) of this title.

(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c), the Secretary shall—

(A) terminate the facility's provider agreement in accordance with the provisions of section 1396i(b) of this title; or

(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

(f) Applicability of section limited to plans approved by January 1, 1990

The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by January 1, 1990.

(Aug. 14, 1935, ch. 531, title XIX, §1922, formerly §1919, as added Pub. L. 99–272, title IX, §9516(a), Apr. 7, 1986, 100 Stat. 213; renumbered §1922 and amended Pub. L. 100–203, title IV, §§4211(a)(2), 4212(e)(5), Dec. 22, 1987, 101 Stat. 1330–182; amended Pub. L. 100–360, title IV, §411(*l*)(6)(E), July 1, 1988, 102 Stat. 804; Pub. L. 100–647, title VIII, §8433(a), Nov. 10, 1988, 102 Stat. 3804.)

Editorial Notes

PRIOR PROVISIONS

A prior section 1922 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

1988—Subsec. (a). Pub. L. 100–647, §8433(a)(1), inserted ''(including failure to provide active treatment)'' after ''residents'' in introductory provisions.

Subsec. (c)(5). Pub. L. 100–647, §8433(a)(2), inserted '', and to provide active treatment for,'' after ''safety of''.

Subsec. (e)(1), (2)(A). Pub. L. 100–360, §411(*l*)(6)(E), substituted ''1396i(b)'' for ''1396i(c)''.

Subsec. (f). Pub. L. 100–647, §8433(a)(3), substituted ''by January 1, 1990'' for ''within 3 years after the effective date of final regulations implementing this section''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8433(b), Nov. 10, 1988, 102 Stat. 3805, provided that: ''The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Nov. 10, 1988], and shall apply to any proceeding where there has not yet been a final determination by the Secretary (as defined for purposes of judicial review) as of the date of the enactment of this Act.''

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by 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.

EFFECTIVE DATE

Pub. L. 99–272, title IX, §9516(b), Apr. 7, 1986, 100 Stat. 215, provided that:

''(1) The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].

''(2) The Secretary of Health and Human Services shall issue a notice of proposed rulemaking with respect to section 1919 of the Social Security Act [42 U.S.C. 1396r–3] within 60 days after the date of the enactment of this Act, and shall allow a period of 30 days for comment thereon prior to promulgating final regulations implementing such section.''

REGULATIONS

Pub. L. 100–203, title IV, §4217, Dec. 22, 1987, 101 Stat. 1330–220, provided that:

''(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act [Dec. 22, 1987], the Secretary of Health and Human Services shall promulgate final regulations to implement the amendments made by section 9516 of the Consolidated Omnibus Budget Reconciliation Act of 1985 [enacting this section].

''(b) The regulations promulgated under paragraph (1) shall be effective as if promulgated on the date of enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Apr. 7, 1986].''

REPORT TO CONGRESS ON IMPLEMENTATION AND RESULTS OF THIS SECTION

Pub. L. 99–272, title IX, §9516(c), Apr. 7, 1986, 100 Stat. 215, as amended by Pub. L. 100–203, title IV, §4211(*l*), Dec. 22, 1987, 101 Stat. 1330–207, directed Secretary of Health and Human Services to submit a report to Congress on implementation and results of this section, such report to be submitted not later than 30 months after the effective date of final regulations promulgated to implement this section.

§ 1396r–4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this subchapter shall not be considered to meet the requirements of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients (including such patients who receive benefits through a managed care entity) served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term ''medicaid inpatient utilization rate'' means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term ''inpatient day'' includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term ''low-income utilization rate'' means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1396b(w)(1)(A)(iii) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1396b(w)(4) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g), in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph[1] (b)(3)); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term ''obstetrician'' includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2)) of not less than 1 percent.

(e) Special rule

(1) A State plan shall be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a)

[1] So in original. Probably should be ''subsection''.

if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c).

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis, beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) (other than the last sentence of subsection (c)) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) shall apply, and

(D) subsection (g) shall apply.

(f) Limitation on Federal financial participation

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as ''DSH'') allotment for the State for the fiscal year, as specified in paragraphs (2), (3), and (7).

(2) State DSH allotments for fiscal years 1998 through 2002

Subject to paragraph (4), the DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	49	49	49
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0.1	0.1	0.1.

(3) State DSH allotments for fiscal year 2003 and thereafter

(A) In general

Except as provided in paragraphs (6), (7), and (8) and subparagraphs (E) and (F), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) Limitation

The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of—

(i) the DSH allotment for the previous year, or

(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(C) Special, temporary increase in allotments on a one-time, non-cumulative basis

The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

(i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(D) Fiscal year specified

For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before December 8, 2003.

(E) Temporary increase in allotments during recession

(i) In general

Subject to clause (ii), the DSH allotment for any State—

(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraphs (B) and (C);

(II) for fiscal year 2010 is equal to 102.5 percent of the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph determined without applying subclauses (I) and (II).

(ii) Application

Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.

(F) Allotments during the coronavirus temporary medicaid FMAP increase

(i) In general

Notwithstanding any other provision of this subsection, for any fiscal year for which the Federal medical assistance percentage applicable to expenditures under this section is increased pursuant to section 6008 of the Families First Coronavirus Response Act, the Secretary shall recalculate the annual DSH allotment, including the DSH allotment specified under paragraph (6)(A)(vi), to ensure that the total DSH payments (including both Federal and State shares) that a State may make related to a fiscal year is equal to the total DSH payments that the State could have made for such fiscal year without such increase to the Federal medical assistance percentage.

(ii) No application to allotments beginning after COVID–19 emergency period

The DSH allotment for any State for the first fiscal year beginning after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title or any succeeding fiscal year shall be determined under this paragraph without regard to the DSH allotments determined under clause (i).

(4) Special rule for fiscal years 2001 and 2002

(A) In general

Notwithstanding paragraph (2), the DSH allotment for any State for—

(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2000; and

(ii) fiscal year 2002, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2001.

(B) Limitation

Subparagraph (B) of paragraph (3) shall apply to subparagraph (A) of this paragraph in the same manner as that subparagraph (B) applies to paragraph (3)(A).

(C) No application to allotments after fiscal year 2002

The DSH allotment for any State for fiscal year 2003 or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotments determined under subparagraph (A) of this paragraph.

(5) Special rule for low DSH States

(A) For fiscal years 2001 through 2003 for extremely low DSH States

In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years before fiscal year 2004, such in-

creased allotment is subject to an increase for inflation as provided in paragraph (3)(A).

(B) For fiscal year 2004 and subsequent fiscal years

In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

(i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

(ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and

(iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).

(6) Allotment adjustments

(A) Tennessee

(i) In general

Only with respect to fiscal year 2007, the DSH allotment for Tennessee for such fiscal year, notwithstanding the table set forth in paragraph (2) or the terms of the TennCare Demonstration Project in effect for the State, shall be the greater of—

(I) the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for the demonstration year ending in 2006 that is reflected in the budget neutrality provision of the TennCare Demonstration Project; and

(II) $280,000,000.

Only with respect to fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for the fiscal year, notwithstanding such table or terms, shall be the amount specified in the previous sentence for fiscal year 2007. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¼ of the amount specified in the first sentence for fiscal year 2007.

(ii) Limitation on amount of payment adjustments eligible for Federal financial participation

Payment under section 1396b(a) of this title shall not be made to Tennessee with respect to the aggregate amount of any payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for period[2] in fiscal year 2012 described in clause (i) that is in excess of 30 percent of the DSH allotment for the State for such fiscal year or period determined pursuant to clause (i).

(iii) State plan amendment

The Secretary shall permit Tennessee to submit an amendment to its State plan under this subchapter that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals. For purposes of demonstrating budget neutrality under the TennCare Demonstration Project, payment adjustments made pursuant to a State plan amendment approved in accordance with this subparagraph shall be considered expenditures under such project.

(iv) Offset of Federal share of payment adjustments for fiscal years 2007 through 2011 and the first calendar quarter of fiscal year 2012 against Essential Access Hospital supplemental pool payments under the TennCare Demonstration Project

(I) The total amount of Essential Access Hospital supplemental pool payments that may be made under the TennCare Demonstration Project for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) shall be reduced on a dollar for dollar basis by the amount of any payments made under section 1396b(a) of this title to Tennessee with respect to payment adjustments made under this section for hospitals in the State for such fiscal year or period.

(II) The sum of the total amount of payments made under section 1396b(a) of this title to Tennessee with respect to payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) and the total amount of Essential Access Hospital supplemental pool payments made under the TennCare Demonstration Project for such fiscal year or period shall not exceed the State's DSH allotment for such fiscal year or period established under clause (i).

(v) Allotment for 2d, 3rd, and 4th quarters of fiscal year 2012 and for fiscal year 2013

Notwithstanding the table set forth in paragraph (2):

(I) 2d, 3rd, and 4th quarters of fiscal year 2012

In the case of a State that has a DSH allotment of $0 for the 2d, 3rd, and 4th quarters of fiscal year 2012, the DSH al-

[2] So in original. Probably should be preceded by ''a''.

lotment shall be $47,200,000 for such quarters.

(II) Fiscal year 2013

In the case of a State that has a DSH allotment of $0 for fiscal year 2013, the DSH allotment shall be $53,100,000 for such fiscal year.

(vi) Allotment for fiscal years 2015 through 2025

Notwithstanding any other provision of this subsection, any other provision of law, or the terms of the TennCare Demonstration Project in effect for the State, the DSH allotment for Tennessee for fiscal year 2015, and for each fiscal year thereafter through fiscal year 2025, shall be $53,100,000 for each such fiscal year.

(B) Hawaii

(i) In general

Only with respect to each of fiscal years 2007 through 2011, the DSH allotment for Hawaii for such fiscal year, notwithstanding the table set forth in paragraph (2), shall be $10,000,000. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $2,500,000.

(ii) State plan amendment

The Secretary shall permit Hawaii to submit an amendment to its State plan under this subchapter that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

(iii) Allotment for 2d, 3rd, and 4th quarter of fiscal year 2012, fiscal year 2013, and succeeding fiscal years

Notwithstanding the table set forth in paragraph (2):

(I) 2d, 3rd, and 4th quarter of fiscal year 2012

The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $7,500,000.

(II) Treatment as a low-DSH State for fiscal year 2013 and succeeding fiscal years

With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

(III) Certain hospital payments

The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.

(7) Medicaid DSH reductions

(A) Reductions

(i) In general

For the period beginning April 1, 2025, and ending September 30, 2025, and for each of fiscal years 2026 through 2027, the Secretary shall effect the following reductions:

(I) Reduction in DSH allotments

The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under subparagraph (B) for the State for the fiscal year or period.

(II) Reductions in payments

The Secretary shall reduce payments to States under section 1396b(a) of this title for each calendar quarter in the fiscal year or period, in the manner specified in clause (iii), in an amount equal to ¼ of the DSH allotment reduction under subclause (I) for the State for the fiscal year or period.

(ii) Aggregate reductions

The aggregate reductions in DSH allotments for all States under clause (i)(I) shall be equal to $8,000,000,000 for the period beginning April 1, 2025, and ending September 30, 2025, and for each of fiscal years 2026 through 2027.

(iii) Manner of payment reduction

The amount of the payment reduction under clause (i)(II) for a State for a quarter shall be deemed an overpayment to the State under this subchapter to be disallowed against the State's regular quarterly draw for all spending under section 1396b(d)(2) of this title. Such a disallowance is not subject to a reconsideration under subsections (d) and (e) of section 1316 of this title.

(iv) Definition

In this paragraph, the term ''State'' means the 50 States and the District of Columbia.

(v) Distribution of aggregate reductions

The Secretary shall distribute the aggregate reductions under clause (ii) among

States in accordance with subparagraph (B).

(B) DSH Health Reform methodology

The Secretary shall carry out subparagraph (A) through use of a DSH Health Reform methodology that meets the following requirements:

(i) The methodology imposes the largest percentage reductions on the States that—

(I) have the lowest percentages of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent year for which such data are available; or

(II) do not target their DSH payments on—

(aa) hospitals with high volumes of Medicaid inpatients (as defined in subsection (b)(1)(A)); and

(bb) hospitals that have high levels of uncompensated care (excluding bad debt).

(ii) The methodology imposes a smaller percentage reduction on low DSH States described in paragraph (5)(B).

(iii) The methodology takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1315 of this title as of July 31, 2009.

(8) Calculation of DSH allotments after reductions period

The DSH allotment for a State for fiscal years after fiscal year 2027 shall be calculated under paragraph (3) without regard to paragraph (7).

(9) "State" defined

In this subsection, the term ''State'' means the 50 States and the District of Columbia.

(g) Limit on amount of payment to hospital

(1) In general

(A) Amount of adjustment subject to uncompensated costs

A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital (other than a hospital described in paragraph (2)(B)) if the payment adjustment exceeds an amount equal to—

(i) the costs incurred during the year of furnishing hospital services by the hospital to individuals described in subparagraph (B) minus—

(ii) the sum of—

(I) payments under this subchapter (other than under this section) for such services; and

(II) payments by uninsured patients for such services.

(B) Individuals described

For purposes of subparagraph (A), the individuals described in this clause are the following:

(i) Individuals who are eligible for medical assistance under the State plan or under a waiver of such plan and for whom the State plan or waiver is the primary payor for such services.

(ii) Subject to subparagraph (C), individuals who have no health insurance (or other source of third party coverage) for services provided during the year, as determined by the Secretary.

(C) Exclusion of certain payments

For purposes of subparagraph (B)(ii), payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party coverage.

(2) Application of limits for certain hospitals

(A) In general

A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital described in subparagraph (B) if the payment adjustment exceeds the higher of—

(i) the amount determined for the hospital and fiscal year under paragraph (1)(A); and

(ii) the amount determined for the hospital under paragraph (1)(A) as in effect on January 1, 2020.

(B) Hospitals described

A hospital is described in this subparagraph for a fiscal year if, for the most recent cost reporting period, the hospital is in at least the 97th percentile of all hospitals with respect to—

(i) the number of inpatient days for such period that were made up of patients who (for such days) were entitled to benefits under part A of subchapter XVIII and were entitled to supplemental security income benefits under subchapter XVI (excluding any State supplementary benefits paid with respect to such patients); or

(ii) the percentage of total inpatient days that were made up of patients who (for such days) were described in clause (i).

(3) Continued application of grandfathered transition rule

Notwithstanding paragraph (2) of this subsection (as in effect on October 1, 2021), paragraph (2) of this subsection (as in effect on September 30, 2021, and as applied under section 4721(e) of the Balanced Budget Act of 1997, and amended by section 607 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Public Law 106–113)) shall apply in determining whether a payment adjustment for a hospital in a State referenced in section 4721(e) of the Balanced Budget Act of 1997 during a State fiscal year shall be considered consistent with subsection (c).

(h) Limitation on certain State DSH expenditures

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning

with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH payment adjustments

The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) Applicable percentage of 1995 total DSH payment allotment

The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) Applicable percentage

(A) In general

For purposes of paragraph (1), the applicable percentage with respect to—

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 percentage

The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) State 1995 DSH spending amount

For purposes of subparagraph (B)(ii), the ''State 1995 DSH spending amount'', with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) Requirement for direct payment

(1) In general

No payment may be made under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) Exception for current arrangements

Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

(j) Annual reports and other requirements regarding payment adjustments

With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, to do the following:

(1) Report

The State shall submit an annual report that includes the following:

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) Independent certified audit

The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this subchapter, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this subchapter, claimed expenditures under this subchapter, uninsured costs in determining payment adjustments under this sec-

tion, and any payments made on behalf of the uninsured from payment adjustments under this section.

(Aug. 14, 1935, ch. 531, title XIX, § 1923, formerly Pub. L. 100–203, title IV, § 4112, Dec. 22, 1987, 101 Stat. 1330–148; renumbered § 1923 of act Aug. 14, 1935, and amended Pub. L. 100–360, title III, § 302(b)(2), title IV, § 411(k)(6)(A)–(B)(ix), July 1, 1988, 102 Stat. 752, 792–794; Pub. L. 100–485, title VI, § 608(d)(15)(C), (26)(A)–(F), Oct. 13, 1988, 102 Stat. 2417, 2421, 2422; Pub. L. 101–239, title VI, § 6411(c)(1), Dec. 19, 1989, 103 Stat. 2270; Pub. L. 101–508, title IV, §§ 4702(a), 4703(a)–(c), Nov. 5, 1990, 104 Stat. 1388–171; Pub. L. 102–234, §§ 3(b)(1), (2)(A), (c), Dec. 12, 1991, 105 Stat. 1799, 1802, 1803; Pub. L. 103–66, title XIII, § 13621(a)(1), (b)(1), (2), Aug. 10, 1993, 107 Stat. 629–631; Pub. L. 105–33, title IV, §§ 4711(c)(2), 4721(a)(1), (b)–(d), Aug. 5, 1997, 111 Stat. 508, 511, 513, 514; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, §§ 601(a), 608(s)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, 1501A–397; Pub. L. 106–554, § 1(a)(6) [title VII, § 701(a)(1), (2), (b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–569, 2763A–570; Pub. L. 108–173, title X, § 1001(a)–(d), Dec. 8, 2003, 117 Stat. 2428–2430; Pub. L. 109–171, title VI, § 6054(a), Feb. 8, 2006, 120 Stat. 96; Pub. L. 109–432, div. B, title IV, § 404, Dec. 20, 2006, 120 Stat. 2995; Pub. L. 110–173, title II, § 204, Dec. 29, 2007, 121 Stat. 2513; Pub. L. 110–275, title II, § 202, July 15, 2008, 122 Stat. 2591; Pub. L. 111–3, title VI, § 616, Feb. 4, 2009, 123 Stat. 103; Pub. L. 111–5, div. B, title V, § 5002, Feb. 17, 2009, 123 Stat. 502; Pub. L. 111–148, title II, § 2551(a), title X, § 10201(e), Mar. 23, 2010, 124 Stat. 312, 920; Pub. L. 111–152, title I, § 1203, Mar. 30, 2010, 124 Stat. 1053; Pub. L. 112–96, title III, § 3203, Feb. 22, 2012, 126 Stat. 193; Pub. L. 112–240, title VI, § 641, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 113–67, div. B, title II, § 1204(a), Dec. 26, 2013, 127 Stat. 1199; Pub. L. 113–93, title II, § 221(a), Apr. 1, 2014, 128 Stat. 1076; Pub. L. 114–10, title II, § 219, title IV, § 412, Apr. 16, 2015, 129 Stat. 153, 162; Pub. L. 115–123, div. E, title XII, § 53101, Feb. 9, 2018, 132 Stat. 298; Pub. L. 116–59, div. B, title III, § 1303, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title III, § 1303, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, § 203, Dec. 20, 2019, 133 Stat. 3111; Pub. L. 116–136, div. A, title III, § 3813, Mar. 27, 2020, 134 Stat. 429; Pub. L. 116–159, div. C, title III, § 2303, Oct. 1, 2020, 134 Stat. 732; Pub. L. 116–215, div. B, title I, § 1106, Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §§ 201, 203(a), Dec. 27, 2020, 134 Stat. 2977, 2978; Pub. L. 117–2, title IX, § 9819(a), Mar. 11, 2021, 135 Stat. 218; Pub. L. 117–7, § 2(b), Apr. 14, 2021, 135 Stat. 252; Pub. L. 118–15, div. B, title III, § 2341, Sept. 30, 2023, 137 Stat. 96; Pub. L. 118–22, div. B, title II, § 301, Nov. 17, 2023, 137 Stat. 121; Pub. L. 118–35, div. B, title I, § 121, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, § 210, Mar. 9, 2024, 138 Stat. 414; Pub. L. 118–158, div. C, title IV, § 3401, Dec. 21, 2024, 138 Stat. 1767.)

Editorial Notes

References in Text

Section 6008 of the Families First Coronavirus Response Act, referred to in subsec. (f)(3)(F), is section 6008 of Pub. L. 116–127, which amended section 1396d of this title and enacted provisions set out as a note under section 1396d of this title.

Section 4721(e) of the Balanced Budget Act of 1997, and amended by section 607 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Public Law 106–113), referred to in subsec. (g)(3), is Pub. L. 105–33, title IV, § 4721(e), Aug. 5, 1997, 111 Stat. 514, as amended by Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 607(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, which is set out as a note under this section.

Codification

Prior to redesignation by Pub. L. 100–360, section 4112 of Pub. L. 100–203, cited in the credits to this section, was classified as a note under section 1396a of this title.

Prior Provisions

A prior section 1923 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

Amendments

2024—Subsec. (f)(7)(A). Pub. L. 118–158 substituted ''April 1'' for ''January 1'' in introductory provisions of cl. (i) and in cl. (ii).

Pub. L. 118–42, in introductory provisions of cl. (i), substituted ''For the period beginning January 1, 2025, and ending September 30, 2025, and for each of fiscal years 2026'' for ''For the period beginning March 9, 2024, and ending September 30, 2024, and for each of fiscal years 2025'' and, in cl. (ii), substituted ''January 1, 2025, and ending September 30, 2025, and for each of fiscal years 2026'' for ''March 9, 2024, and ending September 30, 2024, and for each of fiscal years 2025''.

Pub. L. 118–35 substituted ''March 9, 2024'' for ''January 20, 2024'' in introductory provisions of cl. (i) and in cl. (ii).

2023—Subsec. (f)(7)(A)(i). Pub. L. 118–22, § 301(1), substituted ''January 20, 2024'' for ''November 18, 2023'' in introductory provisions.

Pub. L. 118–15, § 2341(1), substituted ''For the period beginning November 18, 2023, and ending September 30, 2024, and for each of fiscal years 2025 through 2027'' for ''For each of fiscal years 2024 through 2027'' in introductory provisions and inserted ''or period'' after ''the fiscal year'' wherever appearing in subcls. (I) and (II).

Subsec. (f)(7)(A)(ii). Pub. L. 118–22, § 301(2), substituted ''January 20, 2024'' for ''November 18, 2023''.

Pub. L. 118–15, § 2341(2), substituted ''for the period beginning November 18, 2023, and ending September 30, 2024, and for each of fiscal years 2025 through 2027.'' for ''for each of fiscal years 2024 through 2027''.

2021—Subsec. (f)(3)(A). Pub. L. 117–2, § 9819(a)(1), substituted ''subparagraphs (E) and (F)'' for ''subparagraph (E)''.

Subsec. (f)(3)(F). Pub. L. 117–2, § 9819(a)(2), added subpar. (F).

Subsec. (g)(3). Pub. L. 117–7 added par. (3).

2020—Subsec. (f)(7)(A)(i). Pub. L. 116–260, § 201(1)(A), substituted ''For each of fiscal years 2024 through 2027,'' for ''For the period beginning December 19, 2020, and ending September 30, 2021, and for each of fiscal years 2022 through 2025'' in introductory provisions.

Pub. L. 116–215 substituted ''December 19, 2020'' for ''December 12, 2020'' in introductory provisions.

Pub. L. 116–159, § 2303(1), substituted ''December 12, 2020'' for ''December 1, 2020'' in introductory provisions.

Pub. L. 116–136, § 3813(1), substituted ''December 1, 2020, and ending September 30, 2021, and for each of fiscal years 2022'' for ''May 23, 2020, and ending September 30, 2020, and for each of fiscal years 2021'' in introductory provisions.

Subsec. (f)(7)(A)(ii). Pub. L. 116–260, § 201(1)(B), substituted ''equal to $8,000,000,000 for each of fiscal years 2024 through 2027'' for ''equal to—

''(I) $4,000,000,000 for the period beginning December 19, 2020, and ending September 30, 2021; and

''(II) $8,000,000,000 for each of fiscal years 2022 through 2025.''

Subsec. (f)(7)(A)(ii)(I). Pub. L. 116–215 substituted ''December 19, 2020'' for ''December 12, 2020''.

Pub. L. 116–159, §2303(2), substituted ''December 12, 2020'' for ''December 1, 2020''.

Pub. L. 116–136, §3813(2)(A), substituted ''December 1, 2020, and ending September 30, 2021'' for ''May 23, 2020, and ending September 30, 2020''.

Subsec. (f)(7)(A)(ii)(II). Pub. L. 116–136, §3813(2)(B), substituted ''2022'' for ''2021''.

Subsec. (f)(8). Pub. L. 116–260, §201(2), substituted ''2027'' for ''2025''.

Subsec. (g). Pub. L. 116–260, §203(a), amended subsec. (g) generally. Prior to amendment, subsec. (g) related to limit on amount of payment to hospital.

2019—Subsec. (f)(7)(A). Pub. L. 116–94 substituted ''May 23, 2020'' for ''December 21, 2019'' in cls. (i) and (ii)(I).

Pub. L. 116–69 substituted ''December 21, 2019'' for ''November 22, 2019'' in cls. (i) and (ii)(I).

Subsec. (f)(7)(A)(i). Pub. L. 116–59, §1303(1), in introductory provisions, substituted ''For the period beginning November 22, 2019, and ending September 30, 2020, and for each of fiscal years 2021 through 2025'' for ''For each of fiscal years 2020 through 2025''.

Subsec. (f)(7)(A)(ii)(I). Pub. L. 116–59, §1303(2), substituted ''for the period beginning November 22, 2019, and ending September 30, 2020'' for ''for fiscal year 2020''.

2018—Subsec. (f)(7)(A)(i). Pub. L. 115–123, §53101(1), substituted ''2020'' for ''2018'' in introductory provisions.

Subsec. (f)(7)(A)(ii)(I) to (VIII). Pub. L. 115–123, §53101(2), added subcls. (I) and (II) and struck out former subcls. (I) to (VIII) which related to fiscal years 2018 to 2025, respectively.

2015—Subsec. (f)(6)(A)(vi). Pub. L. 114–10, §219, added cl. (vi).

Subsec. (f)(7)(A)(i). Pub. L. 114–10, §412(1)(A), substituted ''2018 through 2025'' for ''2017 through 2024'' in introductory provisions.

Subsec. (f)(7)(A)(ii). Pub. L. 114–10, §412(1)(B), added cl. (ii) and struck out former cl. (ii) which related to aggregate reductions for fiscal years 2017 to 2024.

Subsec. (f)(7)(A)(v). Pub. L. 114–10, §412(1)(C), added cl. (v).

Subsec. (f)(8). Pub. L. 114–10, §412(2), substituted ''2025'' for ''2024''.

2014—Subsec. (f)(7)(A)(i). Pub. L. 113–93, §221(a)(1)(A), substituted ''2017 through 2024'' for ''2016 through 2020'' in introductory provisions.

Subsec. (f)(7)(A)(ii)(I) to (VIII). Pub. L. 113–93, §221(a)(1)(B), added subcls. (I) to (VIII) and struck out former subcls. (I) to (IV) which related to amounts for fiscal years 2016 to 2019.

Subsec. (f)(8). Pub. L. 113–93, §221(a)(2), added par. (8) and struck out former par. (8) which related to special rules for calculating DSH allotments for certain fiscal years.

2013—Subsec. (f)(7)(A)(i). Pub. L. 113–67, §1204(a)(1)(A), substituted ''2016'' for ''2014'' in introductory provisions.

Subsec. (f)(7)(A)(ii). Pub. L. 113–67, §1204(a)(1)(B), redesignated subcls. (III) to (VII) as subcls. (I) to (V), respectively, in subcl. (I), substituted ''$1,200,000,000'' for ''$600,000,000'', and struck out former subcls. (I) and (II) which read as follows:

''(I) $500,000,000 for fiscal year 2014;

''(II) $600,000,000 for fiscal year 2015;''.

Subsec. (f)(8). Pub. L. 112–240 amended par. (8) generally. Prior to amendment, text read as follows: ''With respect to fiscal year 2021, for purposes of applying paragraph (3)(A) to determine the DSH allotment for a State, the amount of the DSH allotment for the State under paragraph (3) for fiscal year 2020 shall be equal to the DSH allotment as reduced under paragraph (7).''

Subsec. (f)(8)(C), (D). Pub. L. 113–67, §1204(a)(2), added subpar. (C) and redesignated former subpar. (C) as (D), and in subpar. (D), substituted ''fiscal year 2023'' for ''fiscal year 2022''.

2012—Subsec. (f)(3)(A). Pub. L. 112–96, §3203(2), substituted ''paragraphs (6), (7), and (8)'' for ''paragraphs (6) and (7)''.

Subsec. (f)(8), (9). Pub. L. 112–96, §3203(1), (3), added par. (8) and redesignated former par. (8) as (9).

2010—Subsec. (f)(1). Pub. L. 111–148, §2551(a)(1), substituted '', (3), and (7)'' for ''and (3)''.

Subsec. (f)(3)(A). Pub. L. 111–148, §2551(a)(2), substituted ''paragraphs (6) and (7)'' for ''paragraph (6)''.

Subsec. (f)(6). Pub. L. 111–148, §10201(e)(1)(A)(i), substituted ''Allotment adjustments'' for ''Allotment adjustments for fiscal years 2007 through 2011 and the first calendar quarter of fiscal year 2012'' in heading.

Subsec. (f)(6)(A)(v). Pub. L. 111–152, §1203(b), added cl. (v).

Subsec. (f)(6)(B)(iii). Pub. L. 111–152, §1203(a)(1), struck out ''or paragraph (7)'' after ''paragraph (2)'' in introductory provisions.

Pub. L. 111–148, §10201(e)(1)(A)(ii), added cl. (iii).

Subsec. (f)(7). Pub. L. 111–152, §1203(a)(2), added par. (7) and struck out former par. (7) which related to reduction of State DSH allotments once reduction in uninsured threshold reached.

Pub. L. 111–148, §2551(a)(4), added par. (7). Former par. (7) redesignated (8).

Subsec. (f)(7)(A). Pub. L. 111–148, §10201(e)(1)(B)(i), substituted ''subparagraphs (E) and (G)'' for ''subparagraph (E)'' in introductory provisions.

Subsec. (f)(7)(B)(i). Pub. L. 111–148, §10201(e)(1)(B)(ii)(I), added subcls. (I) to (IV) and struck out former subcls. (I) and (II) which read as follows:

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

''(II) if the State is any other State, the applicable percentage is 50 percent.''

Subsec. (f)(7)(B)(ii). Pub. L. 111–148, §10201(e)(1)(B)(ii)(II), added subcls. (I) to (IV) and struck out former subcls. (I) and (II) which read as follows:

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

''(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.''

Subsec. (f)(7)(E). Pub. L. 111–148, §10201(e)(1)(B)(ii)(III), which directed amendment of par. (7)(B) by substituting ''50 percent'' for ''35 percent'' in subpar. (E), was executed by making the substitution in par. (7)(E) to reflect the probable intent of Congress.

Subsec. (f)(7)(G). Pub. L. 111–148, §10201(e)(1)(B)(ii)(IV), which directed amendment of par. (7)(B) by adding subpar. (G) at the end, was executed by adding subpar. (G) at end of par. (7) to reflect the probable intent of Congress.

Subsec. (f)(8). Pub. L. 111–148, §2551(a)(3), redesignated par. (7) as (8).

2009—Subsec. (f)(3)(A). Pub. L. 111–5, §5002(1), substituted ''paragraph (6) and subparagraph (E)'' for ''paragraph (6)''.

Subsec. (f)(3)(E). Pub. L. 111–5, §5002(2), added subpar. (E).

Subsec. (f)(6). Pub. L. 111–3, §616(1), substituted ''2011 and the first calendar quarter of fiscal year 2012'' for ''2009 and the first calendar quarter of fiscal year 2010'' in heading.

Subsec. (f)(6)(A)(i). Pub. L. 111–3, §616(2)(A), in concluding provisions, substituted ''fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for'' for ''fiscal years 2008 and 2009, the DSH allotment for Tennessee for such portion of'' and ''2012 for the period ending on December 31, 2011'' for ''2010 for the period ending on December 31, 2009''.

Subsec. (f)(6)(A)(ii). Pub. L. 111–3, §616(2)(B), substituted ''2010, 2011, or for period in fiscal year 2012'' for ''or for a period in fiscal year 2010''.

Subsec. (f)(6)(A)(iv). Pub. L. 111–3, §616(2)(C)(i), substituted ''2011 and the first calendar quarter of fiscal

year 2012'' for ''2009 and the first calendar quarter of fiscal year 2010'' in heading.

Subsec. (f)(6)(A)(iv)(I), (II). Pub. L. 111–3, § 616(2)(C)(ii), substituted ''2010, 2011, or for a period in fiscal year 2012'' for ''or for a period in fiscal year 2010''.

Subsec. (f)(6)(B)(i). Pub. L. 111–3, § 616(3)(A), substituted ''2007 through 2011'' for ''2007 through 2009'' and ''2012 for the period ending on December 31, 2011'' for ''2010 for the period ending on December 31, 2009''.

2008—Subsec. (f)(6). Pub. L. 110–275, § 202(1), substituted ''fiscal years 2007 through 2009 and the first calendar quarter of fiscal year 2010'' for ''for fiscal year 2007 and portions of fiscal year 2008'' in heading.

Subsec. (f)(6)(A)(i). Pub. L. 110–275, § 202(2)(A), in concluding provisions, substituted ''fiscal years 2008 and 2009'' for ''fiscal year 2008 for the period ending on June 30, 2008'', struck out ''¾ of'' before ''the amount specified in the previous sentence'', and inserted ''Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¼ of the amount specified in the first sentence for fiscal year 2007.'' at end.

Subsec. (f)(6)(A)(ii). Pub. L. 110–275, § 202(2)(B), substituted '', 2008, 2009, or for a period in fiscal year 2010'' for ''or for a period in fiscal year 2008''.

Subsec. (f)(6)(A)(iv). Pub. L. 110–275, § 202(2)(C), substituted ''fiscal years 2007 through 2009 and the first calendar quarter of fiscal year 2010'' for ''fiscal year 2007 and fiscal year 2008'' in heading and '', 2008, 2009, or for a period in fiscal year 2010'' for ''or for a period in fiscal year 2008'' in subcls. (I) and (II).

Subsec. (f)(6)(B)(i). Pub. L. 110–275, § 202(3), substituted ''each of fiscal years 2007 through 2009'' for ''fiscal year 2007'' in first sentence, inserted last sentence, and struck out former last sentence which read as follows: ''Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $7,500,000.''

2007—Subsec. (f)(6). Pub. L. 110–173, § 204(1), inserted ''and portions of fiscal year 2008'' after ''fiscal year 2007'' in heading.

Subsec. (f)(6)(A)(i). Pub. L. 110–173, § 204(2)(A), inserted concluding provisions.

Subsec. (f)(6)(A)(ii). Pub. L. 110–173, § 204(2)(B), inserted ''or for a period in fiscal year 2008 described in clause (i)'' after ''fiscal year 2007'' and ''or period'' after ''such fiscal year''.

Subsec. (f)(6)(A)(iv). Pub. L. 110–173, § 204(2)(C), inserted ''and fiscal year 2008'' after ''fiscal year 2007'' in heading, ''or for a period in fiscal year 2008 described in clause (i)'' after ''fiscal year 2007'' in subcls. (I) and (II), ''or period'' after ''for such fiscal year'' in subcl. (I), and ''or period'' after ''such fiscal year'' in two places in subcl. (II).

Subsec. (f)(6)(B)(i). Pub. L. 110–173, § 204(3), inserted at end ''Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $7,500,000.''

2006—Subsec. (f)(2). Pub. L. 109–171 under each of the columns for FY 00, FY 01, and FY 02, substituted ''49'' for ''32'' in the entry for the District of Columbia.

Subsec. (f)(6). Pub. L. 109–432 amended heading and text of par. (6) generally, substituting provisions relating to allotment adjustments for fiscal year 2007 in Tennessee and Hawaii for provisions relating to allotment adjustments with respect to fiscal year 2004 or 2005 in any State if a statewide waiver had been revoked or terminated before the end of either such fiscal year and there had been no DSH allotment for the State.

2003—Subsec. (f)(3)(A). Pub. L. 108–173, § 1001(a)(1), (c)(1), substituted ''Except as provided in paragraph (6), the DSH'' for ''The DSH'' and ''subparagraphs (B) and (C)'' for ''subparagraph (B)''.

Subsec. (f)(3)(C), (D). Pub. L. 108–173, § 1001(a)(2), added subpars. (C) and (D).

Subsec. (f)(5). Pub. L. 108–173, § 1001(b)(1), (2), (4), struck out ''extremely'' before ''low DSH States'' in heading, designated existing provisions as subpar. (A) and inserted subpar. heading, and added subpar. (B).

Subsec. (f)(5)(A). Pub. L. 108–173, § 1001(b)(3), which directed insertion of ''before fiscal year 2004'' after ''In subsequent years'', was executed by making the insertion after ''In subsequent fiscal years'' to reflect the probable intent of Congress.

Subsec. (f)(6), (7). Pub. L. 108–173, § 1001(c)(2), (3), added par. (6) and redesignated former par. (6) as (7).

Subsec. (j). Pub. L. 108–173, § 1001(d), added subsec. (j).

2000—Subsec. (a)(2)(D). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(b)(2)(A)], inserted ''(including such patients who receive benefits through a managed care entity)'' after ''the proportion of low-income and medicaid patients''.

Subsec. (b)(2). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(b)(2)(B)], inserted ''(regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity)'' after ''a State plan approved under this subchapter in a period''.

Subsec. (b)(3)(A)(i)(I). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(b)(2)(C)], inserted ''(regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)'' after ''under a State plan under this subchapter''.

Subsec. (f)(2). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(a)(1)(A)(i)], substituted ''Subject to paragraph (4), the DSH allotment'' for ''The DSH allotment'' in introductory provisions.

Subsec. (f)(3)(A). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(a)(2)(B)], inserted ''and paragraph (5)'' after ''subparagraph (B)''.

Subsec. (f)(4). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(a)(1)(A)(iii)], added par. (4). Former par. (4) redesignated (6).

Subsec. (f)(5). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(a)(2)(A)], added par. (5).

Subsec. (f)(6). Pub. L. 106–554, § 1(a)(6) [title VII, § 701(a)(1)(A)(ii)], redesignated par. (4) as (6).

1999—Subsec. (c)(3)(B). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(s)], substituted comma for period at end.

Subsec. (f)(2). Pub. L. 106–113, § 1000(a)(6) [title VI, § 601(a)], under each of the columns for FY 00, FY 01, and FY 02, substituted ''32'' for ''23'' in the entry for the District of Columbia, ''33'' for ''16'' in the entry for Minnesota, ''9'' for ''5'' in the entry for New Mexico, and ''0.1'' for ''0'' in the entry for Wyoming.

1997—Subsec. (a)(1). Pub. L. 105–33, § 4711(c)(2), substituted ''1396a(a)(13)(A)(iv)'' for ''1396a(a)(13)(A)''.

Subsec. (a)(2)(D). Pub. L. 105–33, § 4721(c), added subpar. (D).

Subsec. (e)(1). Pub. L. 105–33, § 4711(c)(2), substituted ''1396a(a)(13)(A)(iv)'' for ''1396a(a)(13)(A)''.

Subsec. (f). Pub. L. 105–33, § 4721(a)(1), amended heading and text of subsec. (f) generally. Prior to amendment, subsec. (f) related to denial of Federal financial participation for payments in excess of certain limits.

Subsec. (h). Pub. L. 105–33, § 4721(b), added subsec. (h).

Subsec. (i). Pub. L. 105–33, § 4721(d), added subsec. (i).

1993—Subsec. (a)(1)(A). Pub. L. 103–66, § 13621(a)(1)(A), substituted ''requirements'' for ''requirement''.

Subsec. (b)(1). Pub. L. 103–66, § 13621(a)(1)(B), substituted ''requirements'' for ''requirement'' in introductory provisions.

Subsec. (c). Pub. L. 103–66, § 13621(b)(2)(A), substituted ''subsections (f) and (g)'' for ''subsection (f)'' in introductory provisions.

Subsec. (d). Pub. L. 103–66, § 13621(a)(1)(C), substituted ''Requirements'' for ''Requirement'' in heading.

Subsec. (d)(3). Pub. L. 103–66, § 13621(a)(1)(D), added par. (3).

Subsec. (e)(1)(C). Pub. L. 103–66, § 13621(a)(1)(E), added cl. (C).

Subsec. (e)(2)(A). Pub. L. 103–66, § 13621(a)(1)(F)(i), inserted ''(other than the last sentence of subsection (c))'' before ''shall not apply''.

Subsec. (e)(2)(C). Pub. L. 103–66, § 13621(a)(1)(F)(ii)–(iv), added subpar. (C).

Subsec. (e)(2)(D). Pub. L. 103–66, § 13621(b)(2)(B), added subpar. (D).

Subsec. (g). Pub. L. 103–66, § 13621(b)(1), added subsec. (g).

1991—Subsec. (a)(2)(B). Pub. L. 102–234, § 3(b)(2)(A)(i), substituted ''subsections (c) and (f)'' for ''subsection (c)''.

Subsec. (b)(4). Pub. L. 102–234, § 3(c), added par. (4).

Subsec. (c). Pub. L. 102–234, § 3(b)(2)(A)(ii), substituted ''Subject to subsection (f), in order'' for ''In order''.

Subsec. (f). Pub. L. 102–234, § 3(b)(1), added subsec. (f).

1990—Subsec. (b)(2). Pub. L. 101–508, § 4702(a), inserted at end ''In this paragraph, the term 'inpatient day' includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.''

Subsec. (c)(2). Pub. L. 101–508, § 4703(c), inserted before semicolon at end ''or the hospital's low-income utilization rate (as defined in paragraph (b)(3))''.

Subsec. (c)(3). Pub. L. 101–508, § 4703(a), added par. (3).

Subsec. (e)(2). Pub. L. 101–508, § 4703(b), struck out ''during the 3-year period'' before ''beginning on''.

1989—Subsec. (e)(1). Pub. L. 101–239 designated portion of existing provisions as cls. (A) and (B), and in cl. (A) designated existing provisions as subcl. (i) and added subcl. (ii).

1988—Pub. L. 100–360, § 411(k)(6)(A)–(B)(ix), as amended by Pub. L. 100–485, § 608(d)(26)(F), amended Pub. L. 100–203, § 4112, so as to redesignate section 4112 of Pub. L. 100–203 as this section.

Subsec. (a). Pub. L. 100–360, § 411(k)(6)(B)(iv), struck out ''of Health and Human Services'' after ''to the Secretary'' wherever appearing in pars. (1) and (2).

Subsec. (a)(1). Pub. L. 100–360, § 411(k)(6)(B)(ii), (iii), substituted ''A State plan under this subchapter'' for ''A State's plan under title XIX of the Social Security Act'', and made technical amendment to reference to section 1396a(a)(13)(A) of this title involving underlying provisions of original act.

Subsec. (a)(2)(A). Pub. L. 100–360, § 411(k)(6)(A)(i), substituted ''April 1, 1989'' for ''such date'' and inserted before period at end '', effective for inpatient hospital services provided on or after July 1, 1989''.

Subsec. (a)(2)(B). Pub. L. 100–360, § 411(k)(6)(A)(ii), substituted ''April 1, 1990'' for ''such date'' and inserted before period at end '', effective for inpatient hospital services provided on or after July 1, 1990''.

Subsec. (a)(2)(C). Pub. L. 100–485, § 608(d)(15)(C), realigned the margin of subpar. (C).

Pub. L. 100–360, § 302(b)(2), added subpar. (C).

Subsec. (a)(3). Pub. L. 100–360, § 411(k)(6)(A)(iii), inserted par. (3) designation and substituted ''90 days after the date a State submits an amendment'' for ''June 30 of each year in which the State is required to submit an amendment''.

Subsec. (a)(4). Pub. L. 100–360, § 411(k)(6)(A)(iii)(II), (III), (B)(v), inserted par. (4) designation and made technical amendment to reference to section 1396n(b)(4) of this title involving underlying provisions of original act.

Subsec. (b)(2). Pub. L. 100–360, § 411(k)(6)(A)(iv), substituted ''a State plan'' for ''the State plan''.

Pub. L. 100–360, § 411(k)(6)(B)(vi), as amended by Pub. L. 100–485, § 608(d)(26)(F), substituted ''under this subchapter'' for ''under subchapter XIX of this chapter''.

Subsec. (b)(3). Pub. L. 100–360, § 411(k)(6)(B)(vi), as amended by Pub. L. 100–485, § 608(d)(26)(F), substituted ''under this subchapter'' for ''under subchapter XIX of this chapter'' in last sentence.

Subsec. (b)(3)(A)(i). Pub. L. 100–360, § 411(k)(6)(B)(vi), as amended by Pub. L. 100–485, § 608(d)(26)(F), substituted ''under this subchapter'' for ''under subchapter XIX of this chapter''.

Subsec. (b)(3)(B)(i). Pub. L. 100–485, § 608(d)(26)(D), inserted ''of subparagraph (A)'' after ''clause (i)(II)''.

Pub. L. 100–360, § 411(k)(6)(A)(v), inserted '', less the portion of any cash subsidies described in clause (i)(II) in the period reasonably attributable to inpatient hospital services'' after ''charity care in a period''.

Subsec. (c). Pub. L. 100–485, § 608(d)(26)(E), substituted ''this subsection'' for ''subsection (c)'' in concluding provisions.

Pub. L. 100–360, § 411(k)(6)(A)(vi)(I), (II), (V), in concluding provisions, substituted ''paragraphs (1)(B) and (2)(A) of subsection (a)'' for ''paragraphs (2)(A) and (2)(B)'', ''such paragraph (1)(B)'' for ''paragraph (2)(A)'', and ''such paragraph (2)(A)'' for ''paragraph (2)(B)'' and inserted ''at least'' before ''one-third'' and ''two-thirds''.

Pub. L. 100–360, § 411(k)(6)(A)(vi)(VI), inserted at end ''In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.''

Subsec. (c)(1). Pub. L. 100–360, § 411(k)(6)(A)(vi)(III), inserted ''at least'' after ''equal to''.

Subsec. (c)(2). Pub. L. 100–360, § 411(k)(6)(A)(vi)(IV), as amended by Pub. L. 100–485, § 608(d)(26)(A), inserted ''(without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1))'' after ''payment) and''.

Subsec. (d)(1). Pub. L. 100–360, § 411(k)(6)(B)(vi), as amended by Pub. L. 100–485, § 608(d)(26)(F), substituted ''under this subchapter'' for ''under subchapter XIX of this chapter''.

Subsec. (d)(2)(B). Pub. L. 100–360, § 411(k)(6)(B)(vii), made technical amendment to reference to section 1395ww of this title involving underlying provisions of original Act.

Subsec. (e). Pub. L. 100–360, § 411(k)(6)(A)(vii), as amended by Pub. L. 100–485, § 608(d)(26)(B), (C), designated existing provisions as par. (1), inserted ''based on a pooling arrangement involving a majority of the hospitals participating under the plan'' after first reference to ''payment adjustments'', added par. (2) and substituted ''statewide'' for ''Statewide'' in par. (2).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–7, § 2(b), Apr. 14, 2021, 135 Stat. 252, provided that the amendment made by section 2(b) is effective as if included in the enactment of section 203(a) of title II of division CC of Public Law 116–260.

Pub. L. 117–2, title IX, § 9819(b), Mar. 11, 2021, 135 Stat. 218, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect and apply as if included in the enactment of the Families First Coronavirus Response Act (Public Law 116–127).''

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title II, § 203(b), Dec. 27, 2020, 134 Stat. 2979, provided that: ''The amendment made by this section [amending this section] shall take effect on October 1, 2021, and shall apply to payment adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) during fiscal years beginning on or after such date.''

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 113–67, div. B, title II, § 1204(b), Dec. 26, 2013, 127 Stat. 1199, provided that: ''The amendments made

by subsection (a) [amending this section] shall be effective as of October 1, 2013.''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2551(b), Mar. 23, 2010, 124 Stat. 314, which provided that the amendments made by subsection (a), amending this section, were effective on Oct. 1, 2011, was repealed by Pub. L. 111–148, title X, §10201(f), Mar. 23, 2010, 124 Stat. 922.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6054(b), Feb. 8, 2006, 120 Stat. 96, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if enacted on October 1, 2005, and shall only apply to disproportionate share hospital adjustment expenditures applicable to fiscal year 2006 and subsequent fiscal years made on or after that date.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] take effect on the date the final regulation required under section 705(a) [114 Stat. 2763A–575] (relating to the application of an aggregate upper payment limit test for State medicaid spending for inpatient hospital services, outpatient hospital services, nursing facility services, intermediate care facility services for the mentally retarded, and clinic services provided by government facilities that are not State-owned or operated facilities) is published in the Federal Register.'' [The final regulation was published Jan. 12, 2001, 66 Fed. Reg. 3147.]

Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(3)(B)], Dec. 21, 2000, 114 Stat. 2763, 2763A–571, provided that: ''The amendments made by paragraph (2) [amending this section] shall apply to payments made on or after January 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §601(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, provided that: ''The amendments made by subsection (a) [amending this section] take effect on October 1, 1999, and applies [sic] to expenditures made on or after such date.''

Amendment by section 1000(a)(6) [title VI, §608(s)] 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 AMENDMENT

Amendment by section 4711(c)(2) 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 1396a of this title.

Pub. L. 105–33, title IV, §4721(a)(2), Aug. 5, 1997, 111 Stat. 512, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to payment adjustments attributable to DSH allotments for fiscal years beginning with fiscal year 1998.''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13621(a)(2), Aug. 10, 1993, 107 Stat. 629, provided that: ''The amendments made by this subsection [amending this section] shall apply to payments to States under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for payments to hospitals made under State plans after—

''(A) the end of the State fiscal year that ends during 1994, or

''(B) in the case of a State with a State legislature which is not scheduled to have a regular legislative session in 1994, the end of the State fiscal year that ends during 1995;

without regard to whether or not final regulations to carry out such amendments have been promulgated by either such date.''

Pub. L. 103–66, title XIII, §13621(b)(3), Aug. 10, 1993, 107 Stat. 631, provided that:

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall apply to payments to States under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for payments to hospitals made under State plans after—

''(i) the end of the State fiscal year that ends during 1994, or

''(ii) in the case of a State with a State legislature which is not scheduled to have a regular legislative session in 1994, the end of the State fiscal year that ends during 1995;

without regard to whether or not final regulations to carry out such amendments have been promulgated by either such date.

''(B) DELAY IN IMPLEMENTATION FOR PRIVATE HOSPITALS.—With respect to a hospital that is not owned or operated by a State (or by an instrumentality or a unit of government within a State), the amendments made by this subsection shall apply to payments to States under section 1903(a) for payments to hospitals made under State plans for State fiscal years that begin during or after 1995, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

EFFECTIVE DATE OF 1991 AMENDMENT

Amendments by Pub. L. 102–234 effective Jan. 1, 1992, see section 3(e)(1) of Pub. L. 102–234, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4702(b), Nov. 5, 1990, 104 Stat. 1388–171, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on July 1, 1990.''

Pub. L. 101–508, title IV, §4703(d), Nov. 5, 1990, 104 Stat. 1388–171, provided that: ''The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 412(a)(2)[4112(a)(2)] of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203, enacting this section].''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by 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 302(b)(2) of Pub. L. 100–360 effective July 1, 1988, see section 302(f)(2) 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(k)(6)(A)–(B)(ix) 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.

APPLICATION OF MEDICAID DSH TRANSITION RULE TO PUBLIC HOSPITALS IN ALL STATES

Pub. L. 106–554, §1(a)(6) [title VII, §701(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–571, provided that:

''(1) IN GENERAL.—During the period described in paragraph (3), with respect to a State, section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111

Stat. 514) [set out as a note below], as amended by section 607 of BBRA [Pub. L. 106–113, §1000(a)(6) [title VI, §607(a)]] (113 Stat. 1501A–396), shall be applied as though—

''(A) 'September 30, 2002' were substituted for 'July 1, 1997' each place it appears;

''(B) 'hospitals owned or operated by a State (as defined for purposes of title XIX of such Act [42 U.S.C. 1396 et seq.]), or by an instrumentality or a unit of government within a State (as so defined)' were substituted for 'the State of California';

''(C) paragraph (3) were redesignated as paragraph (4);

''(D) 'and' were omitted from the end of paragraph (2); and

''(E) the following new paragraph were inserted after paragraph (2):

'(3) ''(as defined in subparagraph (B) but without regard to clause (ii) of that subparagraph and subject to subsection (d))'' were substituted for ''(as defined in subparagraph (B))'' in subparagraph (A) of such section; and'.

''(2) SPECIAL RULE.—With respect to California, section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 514), as so amended, shall be applied without regard to paragraph (1).

''(3) PERIOD DESCRIBED.—The period described in this paragraph is the period that begins, with respect to a State, on the first day of the first State fiscal year that begins after September 30, 2002, and ends on the last day of the succeeding State fiscal year.

''(4) APPLICATION TO WAIVERS.—With respect to a State operating under a waiver of the requirements of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under section 1115 of such Act (42 U.S.C. 1315), the amount by which any payment adjustment made by the State under title XIX of such Act (42 U.S.C. 1396 et seq.), after the application of section 4721(e) of the Balanced Budget Act of 1997 under paragraph (1) to such State, exceeds the costs of furnishing hospital services provided by hospitals described in such section shall be fully reflected as an increase in the baseline expenditure limit for such waiver.''

ASSISTANCE FOR CERTAIN PUBLIC HOSPITALS

Pub. L. 106–554, §1(a)(6) [title VII, §701(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–571, provided that:

''(1) IN GENERAL.—Beginning with fiscal year 2002, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

''(2) HOSPITAL DESCRIBED.—A hospital is described in this paragraph if the hospital—

''(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]), or by an instrumentality or a unit of government within a State (as so defined);

''(B) as of October 1, 2000—

''(i) is in existence and operating as a hospital described in subparagraph (A); and

''(ii) is not receiving disproportionate share hospital payments from the State in which it is located under title XIX of such Act [42 U.S.C. 1396 et seq.]; and

''(C) has a low-income utilization rate (as defined in section 1923(b)(3) of the Social Security Act (42 U.S.C. 1396r–4(b)(3))) in excess of 65 percent.

''(3) LIMITATION ON EXPENDITURES.—

''(A) IN GENERAL.—With respect to any fiscal year, the aggregate amount of Federal financial participation that may be provided for payment adjustments described in paragraph (1) for that fiscal year for all States may not exceed the amount described in subparagraph (B) for the fiscal year.

''(B) AMOUNT DESCRIBED.—The amount described in this subparagraph for a fiscal year is as follows:

''(i) For fiscal year 2002, $15,000,000.

''(ii) For fiscal year 2003, $176,000,000.

''(iii) For fiscal year 2004, $269,000,000.

''(iv) For fiscal year 2005, $330,000,000.

''(v) For fiscal year 2006 and each fiscal year thereafter, $375,000,000.''

DSH PAYMENT ACCOUNTABILITY STANDARDS

Pub. L. 106–554, §1(a)(6) [title VII, §701(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–572, provided that: ''Not later than September 30, 2002, the Secretary of Health and Human Services shall implement accountability standards to ensure that Federal funds provided with respect to disproportionate share hospital adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) are used to reimburse States and hospitals eligible for such payment adjustments for providing uncompensated health care to low-income patients and are otherwise made in accordance with the requirements of section 1923 of that Act.''

DSH ALLOTMENTS FOR SPECIFIC YEARS

Pub. L. 105–277, div. A, §101(f) [title VII, §702], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: ''The amount of the DSH allotment for the State of Minnesota for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act [42 U.S.C. 1396r–4(f)(2)] (as amended by section 4721(a)(1) of Public Law 105–33) is deemed to be $33,000,000.''

Similar provisions were contained in the following prior appropriations act:

Pub. L. 105–78, title VI, §601, Nov. 13, 1997, 111 Stat. 1519.

Pub. L. 105–277, div. A, §101(f) [title VII, §703], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: ''The amount of the DSH allotment for the State of New Mexico for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act [42 U.S.C. 1396r–4(f)(2)] (as amended by section 4721(a)(1) of Public Law 105–33) is deemed to be $9,000,000.''

Pub. L. 105–277, div. A, §101(f) [title VII, §704], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: ''Notwithstanding section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r–4(f)(2)) (as amended by section 4721(a)(1) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 511)[)], the amount of the DSH allotment for Wyoming for fiscal year 1999 is deemed to be $95,000.''

Similar provisions were contained in the following prior appropriations act:

Pub. L. 105–78, title VI, §602, Nov. 13, 1997, 111 Stat. 1519.

CALIFORNIA TRANSITION RULE

Pub. L. 105–33, title IV, §4721(e), Aug. 5, 1997, 111 Stat. 514, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §607(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, provided that: ''Effective July 1, 1997, section 1923(g)(2) of the Social Security Act (42 U.S.C. 1396r–4(g)(2)) shall be applied to the State of California as though—

''(1) '(or that begins on or after July 1, 1997)' were inserted in subparagraph (A) of such section after 'January 1, 1995,';

''(2) '(or 175 percent in the case of a State fiscal year that begins on or after July 1, 1997)' were inserted in subparagraph (A) of such section after '200 percent'; and

''(3) effective for State fiscal years that begin on or after July 1, 1999, 'or (b)(1)(B)' were inserted in section 1923(g)(2)(B)(ii)(I) after '(b)(1)(A)'.''

[Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §607(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, provided that: ''The amendments made by subsection (a) [amending section 4721(e) of Pub. L. 105–33, set out above] shall take effect as if included in the enactment of section 4721(e) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].'']

STUDY OF DSH PAYMENT ADJUSTMENTS

Pub. L. 102–234, §3(d), Dec. 12, 1991, 105 Stat. 1803, directed Prospective Payment Assessment Commission

to conduct a study concerning feasibility and desirability of establishing maximum and minimum payment adjustments under subsec. (c) of this section for hospitals deemed disproportionate share hospitals under State medicaid plans, and criteria (other than criteria described in clause (i) or (ii) of subsec. (f)(1)(D)) that are appropriate for the designation of disproportionate share hospitals under this section, specified items to be included in study, and directed that, not later than Jan. 1, 1994, Commission submit a report on the study to Committee on Finance of Senate and Committee on Energy and Commerce of House of Representatives, such report to include such recommendations respecting designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under this section as may be appropriate.

§ 1396r–5. Treatment of income and resources for certain institutionalized spouses

(a) Special treatment for institutionalized spouses

(1) Supersedes other provisions

In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title) which is inconsistent with them.

(2) No comparable treatment required

Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1396a(a) of this title, require such treatment for other individuals.

(3) Does not affect certain determinations

Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) Application in certain States and territories

(A) Application in States operating under demonstration projects

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 requirements of this section 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.

(B) No application in commonwealths and territories

This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(5) Application to individuals receiving services under PACE programs

This section applies to individuals receiving institutional or noninstitutional services under a PACE demonstration waiver program (as defined in section 1396u–4(a)(7) of this title) or under a PACE program under section 1396u–4 or 1395eee of this title.

(b) Rules for treatment of income

(1) Separate treatment of income

During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) Attribution of income

In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) Non-trust property

Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) Trust property

In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this subchapter (including sections 1396a(a)(17) and 1396p(d) of this title), and

(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if

payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) Property with no instrument

In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) Rebutting ownership

The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) Rules for treatment of resources

(1) Computation of spousal share at time of institutionalization

(A) Total joint resources

There shall be computed (as of the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse)—

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to ½ of such total value.

(B) Assessment

At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this subchapter, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

(2) Attribution of resources at time of initial eligibility determination

In determining the resources of an institutionalized spouse at the time of application for benefits under this subchapter, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

(3) Assignment of support rights

The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship.

(4) Separate treatment of resources after eligibility for benefits established

During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this subchapter, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(5) Resources defined

In this section, the term ''resources'' does not include—

(A) resources excluded under subsection (a) or (d) of section 1382b of this title, and

(B) resources that would be excluded under section 1382b(a)(2)(A) of this title but for the limitation on total value described in such section.

(d) Protecting income for community spouse

(1) Allowances to be offset from income of institutionalized spouse

After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance (described in section 1396a(q)(1) of this title), in an amount not less than the amount specified in section 1396a(q)(2) of this title.

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institu-

tionalized spouse (as provided under section 1396a(r) of this title).

In subparagraph (C), the term ''family member'' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) Community spouse monthly income allowance defined

In this section (except as provided in paragraph (5)), the ''community spouse monthly income allowance'' for a community spouse is an amount by which—

(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) Establishment of minimum monthly maintenance needs allowance

(A) In general

Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) Applicable percent

For purposes of subparagraph (A)(i), the ''applicable percent'' described in this paragraph, effective as of—

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) Cap on minimum monthly maintenance needs allowance

The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

(4) Excess shelter allowance defined

In paragraph (3)(A)(ii), the term ''excess shelter allowance'' means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under section 2014(e) of title 7) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) Court ordered support

If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(6) Application of "income first" rule to revision of community spouse resource allowance

For purposes of this subsection and subsections (c) and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

(e) Notice and fair hearing

(1) Notice

Upon—

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

(2) Fair hearing

(A) In general

If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

(iii) the computation of the spousal share of resources under subsection (c)(1);

(iv) the attribution of resources under subsection (c)(2); or

(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1396a(a)(3) of this title with respect to such determination if an application for benefits under this subchapter has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

(B) Revision of minimum monthly maintenance needs allowance

If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

(C) Revision of community spouse resource allowance

If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) Permitting transfer of resources to community spouse

(1) In general

An institutionalized spouse may, without regard to section 1396p(c)(1) of this title, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

(2) Community spouse resource allowance defined

In paragraph (1), the ''community spouse resource allowance'' for a community spouse is an amount (if any) by which—

(A) the greatest of—

(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

(iii) the amount established under subsection (e)(2); or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) Transfers under court orders

If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1396p of this title shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1)).

(g) Indexing dollar amounts

For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) Definitions

In this section:

(1) The term ''institutionalized spouse'' means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1396a(a)(10)(A)(ii)(VI) of this title, and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term ''community spouse'' means the spouse of an institutionalized spouse.

(Aug. 14, 1935, ch. 531, title XIX, §1924, as added Pub. L. 100–360, title III, §303(a)(1)(B), July 1, 1988, 102 Stat. 754; amended Pub. L. 100–485, title VI, §608(d)(16)(A), Oct. 13, 1988, 102 Stat. 2417; Pub. L. 101–239, title VI, §6411(e)(3), Dec. 19, 1989, 103 Stat. 2271; Pub. L. 101–508, title IV, §§4714(a)–(c), 4744(b)(1), Nov. 5, 1990, 104 Stat. 1388–192, 1388–198; Pub. L. 103–66, title XIII, §§13611(d)(2), 13643(c)(1), Aug. 10, 1993, 107 Stat. 627, 647; Pub. L. 103–252, title I, §125(b), May 18, 1994, 108 Stat. 650; Pub. L. 105–33, title IV, §4802(b)(1), Aug. 5, 1997, 111 Stat. 548; Pub. L. 109–171, title VI, §6013(a), Feb. 8, 2006, 120 Stat. 64; Pub. L. 110–234, title IV, §4002(b)(1)(B), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858.)

Editorial Notes

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 1924 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2008—Subsec. (d)(4)(B). Pub. L. 110–246, § 4002(b)(1)(B), (2)(V), made technical amendment to reference in original act which appears in text as reference to section 2014(e) of title 7.

2006—Subsec. (d)(6). Pub. L. 109–171 added par. (6).

1997—Subsec. (a)(5). Pub. L. 105–33, in heading substituted ''under PACE programs'' for ''from organizations receiving certain waivers'' and in text substituted ''under a PACE demonstration waiver program (as defined in section 1396u–4(a)(7) of this title) or under a PACE program under section 1396u–4 or 1395eee of this title.'' for ''from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or a waiver under section 603(c) of the Social Security Amendments of 1983.''

1994—Subsec. (d)(3)(A)(i). Pub. L. 103–252 substituted ''section 9902(2)'' for ''sections 9847 and 9902(2)''.

1993—Subsec. (a)(5). Pub. L. 103–66, § 13643(c)(1), substituted ''1986 or a waiver under section 603(c) of the Social Security Amendments of 1983'' for ''1986''.

Subsec. (b)(2)(B)(i). Pub. L. 103–66, § 13611(d)(2), substituted ''1396p(d) of this title'' for ''1396a(k) of this title''.

1990—Subsec. (a)(5). Pub. L. 101–508, § 4744(b)(1), added par. (5).

Subsec. (b)(2). Pub. L. 101–508, § 4714(a), substituted ''for purposes of the post-eligibility income determination described in subsection (d)'' for '', after the institutionalized spouse has been determined or redetermined to be eligible for medical assistance''.

Subsec. (c)(1). Pub. L. 101–508, § 4714(c), substituted ''the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse'' for ''the beginning of a continuous period of institutionalization of the institutionalized spouse'' in subpars. (A) and (B).

Subsec. (f)(1). Pub. L. 101–508, § 4714(b), substituted ''section 1396p(c)(1)'' for ''section 1396p''.

1989—Subsecs. (b)(2), (d)(1). Pub. L. 101–239 inserted ''or redetermined'' after ''determined''.

1988—Subsec. (c)(1)(B). Pub. L. 100–485, § 608(d)(16)(A)(i), substituted ''will have a right to a fair hearing under subsection (e)(2)'' for ''has right to a fair hearing under subsection (e)(2)(E) with respect to the determination of the community spouse resource allowance, to provide for an allowance adequate to raise the spouse's income to the minimum monthly maintenance needs allowance''.

Subsec. (c)(2)(B). Pub. L. 100–485, § 608(d)(16)(A)(ii), substituted ''resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds'' for ''resources shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed''.

Subsec. (d)(3)(A)(i). Pub. L. 100–485, § 608(d)(16)(A)(iii), struck out ''nonfarm'' before ''official poverty line''.

Subsec. (d)(4). Pub. L. 100–485, § 608(d)(16)(A)(iv), substituted ''subparagraph (B)'' for ''subparagraph (C)'' in concluding provisions.

Subsec. (e)(2)(A). Pub. L. 100–485, § 608(d)(16)(A)(v), inserted ''if an application for benefits under this subchapter has been made on behalf of the institutionalized spouse'' after ''with respect to such determination'' before period at end of first sentence.

Subsec. (f)(1). Pub. L. 100–485, § 608(d)(16)(A)(vi), substituted ''transfer an amount'' for ''transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount'' and ''as soon as practicable'' for ''as soon as practicable''.

Subsec. (f)(3). Pub. L. 100–485, § 608(d)(16)(A)(vii), substituted ''spouse or a family member'' for ''spouse of a family member''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, § 6013(b), Feb. 8, 2006, 120 Stat. 64, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to transfers and allocations made on or after the date of the enactment of this Act [Feb. 8, 2006] by individuals who become institutionalized spouses on or after such date.''

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–252 effective May 18, 1994, but not applicable to Head Start agencies and other recipients of financial assistance under the Head Start Act (42 U.S.C. 9831 et seq.) until Oct. 1, 1994, see section 127 of Pub. L. 103–252, set out as a note under section 9832 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13611(d)(2) of Pub. L. 103–66 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13611 of Pub. L. 103–66 have been promulgated by such date, see section 13611(e) of Pub. L. 103–66, set out as a note under section 1396p of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4714(d), Nov. 5, 1990, 104 Stat. 1388–192, provided that: ''The amendments made [by] this section [amending this section] shall take effect as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360].''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable as if included in the enactment of section 303 of Pub. L. 100–360, see section 6411(e)(4)(B) of Pub. L. 101–239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by 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.

EFFECTIVE DATE

Pub. L. 100–360, title III, § 303(g), July 1, 1988, 102 Stat. 763, as amended by Pub. L. 100–485, title VI, § 608(d)(16)(D), Oct. 13, 1988, 102 Stat. 2418, provided that:

''(1)(A) The amendments made by this section [enacting this section and amending sections 1382, 1382b, 1396a, 1396p, 1396r, and 1396s of this title] apply (except as provided in this subsection) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(B) Section 1924 of the Social Security Act [42 U.S.C. 1396r–5] (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after September 30,

1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of such date to individuals institutionalized on or after such date.

''(2)(A) The amendment made by subsection (b) [amending section 1396p of this title] and section 1902(a)(51)(B) of the Social Security Act [42 U.S.C. 1396a(a)(51)(B)], apply (except as provided in paragraph (5)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, or the date of the enactment of this Act [July 1, 1988], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(B) Section 1917(c) of the Social Security Act [42 U.S.C. 1396p(c)], as amended by subsection (b) of this section, shall apply to resources disposed of on or after July 1, 1988, except that such section shall not apply with respect to inter-spousal transfers occurring before October 1, 1989.

''(C) Notwithstanding subparagraphs (A) and (B), a State may continue to apply the policies contained in the State plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988, and the laws and policies established by the State as of June 30, 1988, or provided for before July 1, 1988, shall continue to apply through September 30, 1989, (and may, at a State's option continue after such date) to inter-spousal transfers occurring before October 1, 1989.

''(3) The amendments made by subsection (c) [amending sections 1382 and 1382b of this title] shall apply to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(4) The amendment made by subsection (d) [amending section 1396a of this title] is effective on and after April 8, 1988. The final rule of the Health Care Financing Administration published on February 8, 1988 (53 Federal Register 3586) is superseded to the extent inconsistent with the amendment made by subsection (d).

''(5) 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 requirements imposed by the amendments made by this section (other than paragraphs (1) and (5) of subsection (e) [amending section 1396a of this title]), 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 these additional requirements 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. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(6) The amendments made by paragraphs (1) and (5) of subsection (e) [amending section 1396a of this title] shall apply to medical assistance furnished on or after October 1, 1982.''

RULE OF CONSTRUCTION

Pub. L. 116–16, §2(b), Apr. 18, 2019, 133 Stat. 852, provided that:

''(1) PROTECTING STATE SPOUSAL INCOME AND ASSET DISREGARD FLEXIBILITY UNDER WAIVERS AND PLAN AMENDMENTS.—Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1924 of the Social Security Act (42 U.S.C. 1396r–5) shall be construed as prohibiting a State from disregarding an individual's spousal income and assets under a State waiver or plan amendment described in paragraph (2) for purposes of making determinations of eligibility for home and community-based services or home and community-based attendant services and supports under such waiver or plan amendment.

''(2) STATE WAIVER OR PLAN AMENDMENT DESCRIBED.—A State waiver or plan amendment described in this paragraph is any of the following:

''(A) A waiver or plan amendment to provide medical assistance for home and community-based services under a waiver or plan amendment under subsection (c), (d), or (i) of section 1915 of the Social Security Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315).

''(B) A plan amendment to provide medical assistance for home and community-based services for individuals by reason of being determined eligible under section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) or by reason of section 1902(f) of such Act (42 U.S.C. 1396a(f)) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care under which the State disregarded the income and assets of the individual's spouse in determining the initial and ongoing financial eligibility of an individual for such services in place of the spousal impoverishment provisions applied under section 1924 of such Act (42 U.S.C. 1396r–5).

''(C) A plan amendment to provide medical assistance for home and community-based attendant services and supports under section 1915(k) of such Act (42 U.S.C. 1396n(k)).''

Similar provisions were contained in the following prior act:

Pub. L. 116–3, §3(b), Jan. 24, 2019, 133 Stat. 7.

[For additional provisions relating to construction of this section, see section 3(b) of Pub. L. 116–39, section 204(b) of Pub. L. 116–94, section 3812(b) of Pub. L. 116–136, section 2302(b) of Pub. L. 116–159, and section 1105(b) of Pub. L. 116–215, set out as notes under section 1396a of this title.]

PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT

Pub. L. 111–148, title II, §2404, Mar. 23, 2010, 124 Stat. 305, as amended by Pub. L. 116–3, §3(a), Jan. 24, 2019, 133 Stat. 7; Pub. L. 116–16, §2(a), Apr. 18, 2019, 133 Stat. 852; Pub. L. 116–39, §3(a), Aug. 6, 2019, 133 Stat. 1061; Pub. L. 116–94, div. N, title I, §204(a), Dec. 20, 2019, 133 Stat. 3111; Pub. L. 116–136, div. A, title III, §3812(a), Mar. 27, 2020, 134 Stat. 429; Pub. L. 116–159, div. C, title III, §2302(a), Oct. 1, 2020, 134 Stat. 731; Pub. L. 116–215, div. B, title I, §1105(a), Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §205(a), Dec. 27, 2020, 134 Stat. 2983; Pub. L. 117–328, div. FF, title V, §5115, Dec. 29, 2022, 136 Stat. 5941, provided that: ''During the period beginning on January 1, 2014, and ending on September 30, 2027, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though 'is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915 [42 U.S.C. 1396n], under a waiver approved under section 1115 [42 U.S.C. 1315], or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) [42 U.S.C. 1396a(a)(10)(C)] or by reason of section 1902(f) [42 U.S.C. 1396a(f)] or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k) [42 U.S.C. 1396n(k)]' were substituted in such section for '(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI) [42 U.S.C. 1396a(a)(10)(A)(ii)(VI)]'.''

[For provisions relating to construction of section 2404 of Pub. L. 111–148, set out above, see section 3(b) of Pub. L. 116–39, section 204(b) of Pub. L. 116–94, section 3812(b) of Pub. L. 116–136, section 2302(b) of Pub. L. 116–159, section 1105(b) of Pub. L. 116–215, and section 205(b) of Pub. L. 116–260, set out as notes under section 1396a of this title.]

§ 1396r–6. Extension of eligibility for medical assistance

(a) Initial 6-month extension

(1) Requirement

(A) In general

Notwithstanding any other provision of this subchapter but subject to subparagraph

(B) and paragraph (5), each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 602(a)(8)(B)(ii)(II)[1] of this title (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this subchapter during the immediately succeeding 6-month period in accordance with this subsection.

(B) State option to waive requirement for 3 months before receipt of medical assistance

A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.

(2) Notice of benefits

Each State, in the notice of termination of aid under part A of subchapter IV sent to a family meeting the requirements of paragraph (1)—

(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the reporting requirement of subsection (b)(2)(B)(i) and of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

(B) shall include a card or other evidence of the family's entitlement to assistance under this subchapter for the period provided in this subsection.

(3) Termination of extension

(A) No dependent child

Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of subchapter IV.

(B) Notice before termination

No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

(C) Continuation in certain cases until redetermination

With respect to a child who would cease to receive medical assistance because of subparagraph (A) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1396d(a) of this title or clause (i)(IV), (i)(VI), (i)(VII), or (ii)(IX) of section 1396a(a)(10)(A) of this title, the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(4) Scope of coverage

(A) In general

Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of subchapter IV.

(B) State medicaid "wrap-around" option

A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, and similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative—

(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection for the caretaker and the caretaker's family, to make application for such employer coverage, but only if—

(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise), and

(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

(ii) the State shall treat the coverage under such an employer plan as a third party liability (under section 1396a(a)(25) of this title).

Payments for premiums, deductibles, coinsurance, and similar expenses under this subparagraph shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(5) Option of 12-month initial eligibility period

A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.

(b) Additional 6-month extension

(1) Requirement

Notwithstanding any other provision of this subchapter but subject to subsection (a)(5), each State plan approved under this subchapter shall provide that the State shall offer to each family, which has received assistance

[1] See References in Text note below.

during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

(2) Notice and reporting requirements

(A) Notices

(i) Notice during initial extension period of option and requirements

Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a), shall notify the family of the family's option for additional extended assistance under this subsection. Each such notice shall include (I) in the 3rd month notice, a statement of the reporting requirement under subparagraph (B)(i), and, in the 6th month notice, a statement of the reporting requirement under subparagraph (B)(ii), (II) a statement as to whether any premiums are required for such additional extended assistance, and (III) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D). The 6th month notice under this subparagraph shall describe the amount of any premium required of a particular family for each of the first 3 months of additional extended assistance under this subsection.

(ii) Notice during additional extension period of reporting requirements and premiums

Each State, during the 3rd month of any additional extended assistance furnished to a family under this subsection, shall notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of the amount of any premium required for such extended assistance for the succeeding 3 months.

(B) Reporting requirements

(i) During initial extension period

Each State shall require (as a condition for additional extended assistance under this subsection) that a family receiving extended assistance under subsection (a) report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a), on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the first 3 months of that period. A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.

(ii) During additional extension period

Each State shall require that a family receiving extended assistance under this subsection report to the State, not later than the 21st day of the 1st month and of the 4th month in the period of additional extended assistance under this subsection, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the 3 preceding months.

(iii) Clarification on frequency of reporting

A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).

(3) Termination of extension

(A) In general

Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) No dependent child

The extension shall terminate at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of subchapter IV.

(ii) Failure to pay any premium

If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the family has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

(iii) Quarterly income reporting and test

The extension under this subsection shall terminate at the close of the 1st or 4th month of the 6-month period if—

(I) the family fails to report to the State, by the 21st day of such month, the information required under paragraph (2)(B)(ii), unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis;

(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

(III) the State determines that the family's average gross monthly earnings (less such costs for such child care as is necessary for the employment of the caretaker relative) during the immediately preceding 3-month period exceed 185 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.

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information provided under section 602(a)(9)[1] of this title. Instead of terminating a family's extension under clause (iii)(I), a State, at its option, may provide for suspension of the extension until the month after the month in which the family reports information required under paragraph (2)(B)(ii), but only if the family's extension has not otherwise been terminated under subclause (II) or (III) of clause (iii). The State shall make determinations under clause (iii)(III) for a family each time a report under paragraph (2)(B)(ii) for the family is received.

(B) Notice before termination

No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan. No such termination shall be effective earlier than 10 days after the date of mailing of such notice.

(C) Continuation in certain cases until redetermination

(i) Dependent children

With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1396d(a) of this title or clause (i)(IV), (i)(VI), (i)(VII), or (ii)(IX) of section 1396a(a)(10)(A) of this title, the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(ii) Medically needy

With respect to an individual who would cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under section 1396a(a)(10)(C) of this title (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

(4) Coverage

(A) In general

During the extension period under this subsection—

(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under the plan approved under part A of subchapter IV; and

(ii) the State plan may offer alternative coverage described in subparagraph (D).

(B) Elimination of most non-acute care benefits

At a State's option and notwithstanding any other provision of this subchapter, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21)[1] of section 1396d(a) of this title.

(C) State medicaid "wrap-around" option

At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) (relating to ''wrap-around'' coverage) for families electing medical assistance under this subsection in the same manner as such option applies to families provided extended eligibility for medical assistance under subsection (a).

(D) Alternative assistance

At a State's option, the State may offer families a choice of health care coverage under one or more of the following, instead of the medical assistance otherwise made available under this subsection:

(i) Enrollment in family option of employer plan

Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

(ii) Enrollment in family option of State employee plan

Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

(iii) Enrollment in State uninsured plan

Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to individuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

(iv) Enrollment in medicaid managed care organization

Enrollment of the caretaker relative and dependent children in a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title).

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family and may pay deductibles and coinsurance imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) and

payment of any deductibles and coinsurance shall be considered, for purposes of section 1396b(a)(1) of this title, to be payments for medical assistance.

(E) Prohibition on cost-sharing for maternity and preventive pediatric care

(i) In general

If a State offers any alternative option under subparagraph (D) for families, under each such option the State must assure that care described in clause (ii) is available without charge to the families through—

(I) payment of any deductibles, coinsurance, and other cost-sharing respecting such care, or

(II) providing coverage under the State plan for such care without any cost-sharing,

or any combination of such mechanisms.

(ii) Care described

The care described in this clause consists of—

(I) services related to pregnancy (including prenatal, delivery, and post partum services), and

(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under section 1396d(a)(4)(B) of this title) for each child who meets the age and date of birth requirements to be a qualified child under section 1396d(n)(2) of this title.

(5) Premium

(A) Permitted

Notwithstanding any other provision of this subchapter (including section 1396*o* of this title), a State may impose a premium for a family for additional extended coverage under this subsection for a premium payment period (as defined in subparagraph (D)(i)), but only if the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for the premium base period exceed 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) Level may vary by option offered

The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(D).

(C) Limit on premium

In no case may the amount of any premium under this paragraph for a family for a month in either of the premium payment periods described in subparagraph (D)(i) exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) during the premium base period (as defined in subparagraph (D)(ii)).

(D) Definitions

In this paragraph:

(i) A ''premium payment period'' described in this clause is a 3-month period beginning with the 1st or 4th month of the 6-month additional extension period provided under this subsection.

(ii) The term ''premium base period'' means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

(c) Applicability in States and territories

(1) States operating under demonstration projects

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315(a) of this title, the Secretary shall require the State to meet the requirements of this section 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.

(2) Inapplicability in commonwealths and territories

The provisions of this section shall only apply to the 50 States and the District of Columbia.

(d) General disqualification for fraud

(1) Ineligibility for aid

This section shall not apply to an individual who is a member of a family which has received aid under part A of subchapter IV if the State makes a finding that, at any time during the last 6 months in which the family was receiving such aid before otherwise being provided extended eligibility under this section, the individual was ineligible for such aid because of fraud.

(2) General disqualifications

For additional provisions relating to fraud and program abuse, see sections 1320a–7, 1320a–7a, and 1320a–7b of this title.

(e) "Caretaker relative" defined

In this section, the term ''caretaker relative'' has the meaning of such term as used in part A of subchapter IV.

(f) Collection and reporting of participation information

(1) Collection of information from States

Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under subchapter XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this subchapter is submitted to the Secretary.

(2) Annual reports to Congress

Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.

(Aug. 14, 1935, ch. 531, title XIX, § 1925, as added Pub. L. 100–485, title III, § 303(a)(1), Oct. 13, 1988, 102 Stat. 2385; amended Pub. L. 100–647, title VIII, § 8436(a), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–239, title VI, § 6411(i)(1), (3), Dec. 19, 1989, 103 Stat. 2273; Pub. L. 101–508, title IV, §§ 4601(a)(3)(B), 4716(a), Nov. 5, 1990, 104 Stat. 1388–167, 1388–192; Pub. L. 104–193, title I, § 114(c), Aug. 22, 1996, 110 Stat. 2180; Pub. L. 105–33, title IV, §§ 4701(b)(2)(A)(ix), (D), 4703(b)(2), Aug. 5, 1997, 111 Stat. 493, 495; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(t)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 106–554, § 1(a)(6) [title VII, § 707(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–577; Pub. L. 108–40, § 7(a), June 30, 2003, 117 Stat. 837; Pub. L. 111–5, div. B, title V, § 5004(a)(1), (b)–(d), Feb. 17, 2009, 123 Stat. 503, 504; Pub. L. 111–309, title I, § 111, Dec. 15, 2010, 124 Stat. 3289; Pub. L. 112–78, title III, § 311, Dec. 23, 2011, 125 Stat. 1286; Pub. L. 112–96, title III, § 3102, Feb. 22, 2012, 126 Stat. 191; Pub. L. 112–240, title VI, § 622, Jan. 2, 2013, 126 Stat. 2352; Pub. L. 113–67, div. B, title II, § 1202, Dec. 26, 2013, 127 Stat. 1199; Pub. L. 113–93, title II, § 202, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 114–10, title II, § 212(a), Apr. 16, 2015, 129 Stat. 152.)

Editorial Notes

REFERENCES IN TEXT

Section 602 of this title, referred to in subsecs. (a)(1)(A) and (b)(3)(A), was repealed and a new section 602 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. (a)(8)(B)(ii)(II) or (a)(9).

Paragraph (21) of section 1396d(a) of this title, referred to in subsec. (b)(4)(B), was redesignated paragraph (22) by Pub. L. 101–239, title VI, § 6405(a)(2), Dec. 19, 1989, 103 Stat. 2265.

PRIOR PROVISIONS

A prior section 1925 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2015—Subsecs. (f), (g). Pub. L. 114–10 redesignated subsec. (g) as (f) and struck out former subsec. (f). Prior to amendment, text of subsec. (f) read as follows: ''This section shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter after March 31, 2015.''

2014—Subsec. (f). Pub. L. 113–93 substituted ''March 31, 2015'' for ''March 31, 2014''.

2013—Subsec. (f). Pub. L. 113–67 substituted ''March 31, 2014'' for ''December 31, 2013''.

Pub. L. 112–240 substituted ''2013'' for ''2012''.

2012—Subsec. (f). Pub. L. 112–96 substituted ''December 31'' for ''February 29''.

2011—Subsec. (f). Pub. L. 112–78 substituted ''February 29, 2012'' for ''December 31, 2011''.

2010—Subsec. (f). Pub. L. 111–309 substituted ''December 31, 2011'' for ''December 31, 2010''.

2009—Subsec. (a)(1). Pub. L. 111–5, § 5004(c)(2), (3), designated existing provisions as subpar. (A), inserted heading, added subpar. (B), and realigned margins.

Pub. L. 111–5, § 5004(b)(1), (c)(1), inserted ''but subject to subparagraph (B) and paragraph (5)'' after ''Notwithstanding any other provision of this subchapter''.

Subsec. (a)(5). Pub. L. 111–5, § 5004(b)(2), added par. (5).

Subsec. (b)(1). Pub. L. 111–5, § 5004(b)(3), inserted ''but subject to subsection (a)(5)'' after ''Notwithstanding any other provision of this subchapter''.

Subsec. (f). Pub. L. 111–5, § 5004(a)(1), substituted ''December 31, 2010'' for ''September 30, 2003''.

Subsec. (g). Pub. L. 111–5, § 5004(d), added subsec. (g).

2003—Subsec. (f). Pub. L. 108–40 substituted ''2003'' for ''2002''.

2000—Subsec. (f). Pub. L. 106–554 substituted ''2002'' for ''2001''.

1999—Subsec. (a)(3)(C). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(t)(1)], substituted ''(i)(VI), (i)(VII),'' for ''(i)(VI)(i)(VII),,''.

Subsec. (b)(3)(C)(i). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(t)(2)], which directed substitution of ''(i)(IV), (i)(VI), (i)(VII),'' for ''(i)(IV) (i)(VI) (i)(VII),,'', was executed by making the substitution for ''(i)(IV), (i)(VI) (i)(VII),,'' to reflect the probable intent of Congress.

1997—Subsec. (b)(4)(D)(iv). Pub. L. 105–33, § 4703(b)(2), struck out ''less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this subchapter (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a medicaid managed care organization in accordance with section 1396b(m) of this title and the applicable requirements of section 1396u–2 of this title'' after ''(as defined in section 1396b(m)(1)(A) of this title)''.

Pub. L. 105–33, § 4701(b)(2)(A)(ix), substituted ''medicaid managed care organization'' for ''health maintenance organization'' in two places.

Pub. L. 105–33, § 4701(b)(2)(D), substituted ''medicaid managed care organization'' for ''HMO'' in heading and inserted ''and the applicable requirements of section 1396u–2 of this title'' before period at end of text.

1996—Subsec. (f). Pub. L. 104–193 substituted ''2001'' for ''1998''.

1990—Subsec. (a)(3)(C). Pub. L. 101–508, § 4601(a)(3)(B), inserted ''(i)(VII),'' after ''(i)(VI)''.

Subsec. (b)(2)(B)(i). Pub. L. 101–508, § 4716(a)(1), which directed amendment of subsection (f) of this section in subsection (b)(2)(B)(i) by inserting at the end ''A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.'', was executed by making the insertion at the end of subsec. (b)(2)(B)(i) to reflect the probable intent of Congress.

Subsec. (b)(2)(B)(iii). Pub. L. 101–508, § 4716(a)(2), which directed amendment of subsection (f) of this section in subsection (b)(2)(B) by adding cl. (iii) at the end, was executed by adding cl. (iii) at the end of subsec. (b)(2)(B) to reflect the probable intent of Congress.

Subsec. (b)(3)(B). Pub. L. 101–508, § 4716(a)(3), which directed amendment of subsection (f) of this section in subsection (b)(3)(B) by inserting at the end ''No such termination shall be effective earlier than 10 days after the date of mailing of such notice.'', was executed by making the insertion at the end of subsec. (b)(3)(B) to reflect the probable intent of Congress.

Subsec. (b)(3)(C)(i). Pub. L. 101–508, § 4601(a)(3)(B), inserted ''(i)(VII),'' after ''(i)(VI)''.

1989—Subsec. (a)(3)(A). Pub. L. 101–239, § 6411(i)(1), substituted ''a child, whether or not the child is'' for ''a child who is''.

Subsec. (a)(3)(C). Pub. L. 101–239, § 6411(i)(3), substituted ''of section 1396d(a) of this title or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1396a(a)(10)(A) of this title'' for ''or (v) of section 1396d(a) of this title''.

Subsec. (b)(3)(A)(i). Pub. L. 101–239, § 6411(i)(1), substituted ''a child, whether or not the child is'' for ''a child who is''.

Subsec. (b)(3)(C)(i). Pub. L. 101–239, § 6411(i)(3), substituted ''of section 1396d(a) of this title or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1396a(a)(10)(A) of this title'' for ''or (v) of section 1396d(a) of this title''.

1988—Subsec. (b)(5)(C). Pub. L. 100–647, which directed the amendment of subsec. (d)(5)(C) by inserting ''(less the average monthly costs for such child care as is necessary for the employment of the caretaker relative)'' after ''gross monthly earnings'', was executed to subsec. (b)(5)(C) to reflect the probable intent of Congress.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by section 5004(a)(1) of Pub. L. 111–5 effective July 1, 2009, see section 5004(a)(2) of Pub. L. 111–5, set out as a note under section 1396a of this title.

Pub. L. 111–5, div. B, title V, § 5004(e), Feb. 17, 2009, 123 Stat. 505, provided that: ''The amendments made by subsections (b) through (d) [amending this section] shall take effect on July 1, 2009.''

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4701(b)(2)(A)(ix), (D) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710(a) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4703(b)(2) of Pub. L. 105–33 applicable to contracts under section 1396b(m) of this title on and after June 20, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(2) of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4601(a)(3)(B) 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.

Pub. L. 101–508, title IV, § 4716(b), Nov. 5, 1990, 104 Stat. 1388–192, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective as if included in the enactment of the Family Support Act of 1988 [Pub. L. 100–485].''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6411(i)(4), Dec. 19, 1989, 103 Stat. 2273, provided that: ''The amendments made by this subsection [amending this section and provisions set out as a note under section 602 of this title] shall be effective as if included in the enactment of the Family Support Act of 1988 [Pub. L. 100–485].''

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, § 8436(b), Nov. 10, 1988, 102 Stat. 3806, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of the Family Support Act of 1988 [Pub. L. 100–485].''

EFFECTIVE DATE

Section 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 implementing regulations are promulgated by that 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 an Effective Date of 1988 Amendment note under section 1396a of this title.

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.

STUDY AND REPORT TO CONGRESS ON IMPACT OF MEDICAID EXTENSION PROVISIONS

Pub. L. 100–485, title III, § 303(c), Oct. 13, 1988, 102 Stat. 2392, directed Secretary of Health and Human Services to conduct a study of impact of medicaid extension provisions under this section, with particular focus on costs of such provisions and impact on welfare dependency, and report to Congress on results of such study not later than Apr. 1, 1993.

§ 1396r–7. Repealed. Pub. L. 105–33, title IV, § 4713(a), Aug. 5, 1997, 111 Stat. 509

Section, act Aug. 14, 1935, ch. 531, title XIX, § 1926, as added Dec. 19, 1989, Pub. L. 101–239, title VI, § 6402(b), 103 Stat. 2260, related to adequate payment levels for obstetrical and pediatric services.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF REPEAL

Pub. L. 105–33, title IV, § 4713(b), Aug. 5, 1997, 111 Stat. 509, provided that: ''The repeal made by subsection (a) [repealing this section] shall apply to services furnished on or after October 1, 1997.''

§ 1396r–8. Payment for covered outpatient drugs

(a) Requirement for rebate agreement

(1) In general

In order for payment to be available under section 1396b(a) of this title or under part B of subchapter XVIII for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992) and paragraph (6). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall become effective as of the

date on which the agreement is entered into or, at State option, on any date thereafter on or before the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

(2) Effective date

Paragraph (1) shall first apply to drugs dispensed under this subchapter on or after January 1, 1991.

(3) Authorizing payment for drugs not covered under rebate agreements

Paragraph (1), and section 1396b(i)(10)(A) of this title, shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1–A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances. The preceding sentence shall not apply to a single source drug or innovator multiple source drug of a manufacturer for any period described in section 5000D(c)(1) of the Internal Revenue Code of 1986 with respect to the manufacturer.

(4) Effect on existing agreements

In the case of a rebate agreement in effect between a State and a manufacturer on November 5, 1990, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this subchapter. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on November 5, 1990, provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

(5) Limitation on prices of drugs purchased by covered entities

(A) Agreement with Secretary

A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of section 256b of this title with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992.

(B) "Covered entity" defined

In this subsection, the term ''covered entity'' means an entity described in section 256b(a)(4) of this title.

(C) Establishment of alternative mechanism to ensure against duplicate discounts or rebates

If the Secretary does not establish a mechanism under section 256b(a)(5)(A) of this title within 12 months of November 4, 1992, the following requirements shall apply:

(i) Entities

Each covered entity shall inform the single State agency under section 1396a(a)(5) of this title when it is seeking reimbursement from the State plan for medical assistance described in section 1396d(a)(12) of this title with respect to a unit of any covered outpatient drug which is subject to an agreement under section 256b(a) of this title.

(ii) State agency

Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under section 256b of this title, and not submit to any manufacturer a claim for a rebate payment under subsection (b) with respect to such a drug.

(D) Effect of subsequent amendments

In determining whether an agreement under subparagraph (A) meets the requirements of section 256b of this title, the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(E) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 256b of this title (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(6) Requirements relating to master agreements for drugs procured by Department of Veterans Affairs and certain other Federal agencies

(A) In general

A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of section 8126 of title 38, including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

(B) Effect of subsequent amendments

In determining whether a master agreement described in subparagraph (A) meets

the requirements of section 8126 of title 38, the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(C) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 8126 of title 38, (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(7) Requirement for submission of utilization data for certain physician administered drugs

(A) Single source drugs

In order for payment to be available under section 1396b(a) of this title for a covered outpatient drug that is a single source drug that is physician administered under this subchapter (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the collection and submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section for drugs administered for which payment is made under this subchapter.

(B) Multiple source drugs

(i) Identification of most frequently physician administered multiple source drugs

Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of physician administered drugs dispensed under this subchapter. The Secretary may modify such list from year to year to reflect changes in such volume.

(ii) Requirement

In order for payment to be available under section 1396b(a) of this title for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (i), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section.

(C) Use of NDC codes

Not later than January 1, 2007, the information shall be submitted under subparagraphs (A) and (B)(ii) using National Drug Code codes unless the Secretary specifies that an alternative coding system should be used.

(D) Hardship waiver

The Secretary may delay the application of subparagraph (A) or (B)(ii), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.

(b) Terms of rebate agreement

(1) Periodic rebates

(A) In general

A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this subchapter, a rebate for a rebate period in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period, including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) Offset against medical assistance

Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter, including amounts received by a State under subsection (c)(4), shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1396b(a)(1) of this title.

(C) Special rule for increased minimum rebate percentage

(i) In general

In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1396b(a) of this title in the manner specified in clause (ii), in an amount equal to the product of—

(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the ex-

tent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

(ii) Manner of payment reduction

The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this subchapter to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1396b(d)(2) of this title. Such a disallowance is not subject to a reconsideration under section 1316(d) of this title.

(2) State provision of information

(A) State responsibility

Each State agency under this subchapter shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan during the period, including such information reported by each medicaid managed care organization, and shall promptly transmit a copy of such report to the Secretary.

(B) Audits

A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

(3) Manufacturer provision of price and drug product information

(A) In general

Each manufacturer with an agreement in effect under this section shall report to the Secretary—

(i) not later than 30 days after the last day of each rebate period under the agreement—

(I) on the average manufacturer price (as defined in subsection (k)(1)) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)]); and

(II) for single source drugs and innovator multiple source drugs (including all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), on the manufacturer's best price (as defined in subsection (c)(1)(C)) for such drugs for the rebate period under the agreement;

(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1)) as of October 1, 1990 for each of the manufacturer's covered outpatient drugs (including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act);

(iii) for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

(I) the manufacturer's average sales price (as defined in section 1395w–3a(c) of this title) and the total number of units specified under section 1395w–3a(b)(2)(A) of this title;

(II) if required to make payment under section 1395w–3a of this title, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

(III) information on those sales that were made at a nominal price or otherwise described in section 1395w–3a(c)(2)(B) of this title;

for a drug or biological described in subparagraph (C), (D), (E), or (G) of section 1395u(*o*)(1) of this title or section 1395rr(b)(14)(B) of this title, and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs;

(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug; and

(v) not later than 30 days after the last day of each month of a rebate period under the agreement, such drug product information as the Secretary shall require for each of the manufacturer's covered outpatient drugs.

Information reported under this subparagraph is subject to audit by the Inspector General of the Department of Health and Human Services. Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v) (relating to the weighted average of the most recently reported monthly average manufacturer prices). For purposes of applying clause (iii), for calendar quarters beginning on or after January 1, 2022, a drug or biological described in the flush matter following such clause includes items, services, supplies, and products that are payable under part B of subchapter XVIII as a drug or biological.

(B) Verification surveys of average manufacturer price and manufacturer's average sales price

The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1320a–7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(C) Penalties

(i) Failure to provide timely information

In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by $10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

(ii) False information

Any manufacturer with an agreement under this section that knowingly provides false information, including information related to drug pricing, drug product information, and data related to drug pricing or drug product information, is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1320a–7a of this title (other than subsections (a), (b), (f)(3), and (f)(4)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(iii) Misclassified drug product or misreported information

(I) In general

Any manufacturer with an agreement under this section that knowingly (as defined in section 1003.110 of title 42, Code of Federal Regulations (or any successor regulation)) misclassifies a covered outpatient drug, such as by knowingly submitting incorrect drug product information, is subject to a civil money penalty for each covered outpatient drug that is misclassified in an amount not to exceed 2 times the amount of the difference between—

(aa) the total amount of rebates that the manufacturer paid with respect to the drug to all States for all rebate periods during which the drug was misclassified; and

(bb) the total amount of rebates that the manufacturer would have been required to pay, as determined by the Secretary using drug product information provided by the manufacturer, with respect to the drug to all States for all rebate periods during which the drug was misclassified if the drug had been correctly classified.

(II) Other penalties and recovery of underpaid rebates

The civil money penalties described in subclause (I) are in addition to other penalties as may be prescribed by law and any other recovery of the underlying underpayment for rebates due under this section or the terms of the rebate agreement as determined by the Secretary.

(iv) Increasing oversight and enforcement

Each year the Secretary shall retain, in addition to any amount retained by the Secretary to recoup investigation and litigation costs related to the enforcement of the civil money penalties under this subparagraph and subsection (c)(4)(B)(ii)(III), an amount equal to 25 percent of the total amount of civil money penalties collected under this subparagraph and subsection (c)(4)(B)(ii)(III) for the year, and such retained amount shall be available to the Secretary, without further appropriation and until expended, for activities related to the oversight and enforcement of this section and agreements under this section, including—

(I) improving drug data reporting systems;

(II) evaluating and ensuring manufacturer compliance with rebate obligations; and

(III) oversight and enforcement related to ensuring that manufacturers accurately and fully report drug information, including data related to drug classification.

(D) Confidentiality of information

Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A) (other than the wholesale acquisition cost for purposes of carrying out section 1395w–3a of this title) is confidential and

shall not be disclosed by the Secretary or the Secretary of Veterans Affairs or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except—

(i) as the Secretary determines to be necessary to carry out this section, to carry out section 1395w–3a of this title (including the determination and implementation of the payment amount and the rebate), or to carry out section 1395w–3b of this title, section 1320f–1(f) of this title, including rebates under paragraph (4) of such section, or section 1395w–114b of this title,

(ii) to permit the Comptroller General to review the information provided,

(iii) to permit the Director of the Congressional Budget Office to review the information provided,

(iv) to States to carry out this subchapter,

(v) to the Secretary to disclose (through a website accessible to the public) the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f),

(vi) in the case of categories of drug product or classification information that were not considered confidential by the Secretary on the day before April 18, 2019, and

(vii) to permit the Executive Director of the Medicare Payment Advisory Commission and the Executive Director of the Medicaid and CHIP Payment and Access Commission to review the information provided.

The previous sentence shall also apply to information disclosed under section 1395w–102(d)(2) or 1395w–104(c)(2)(G) of this title and drug pricing data reported under the first sentence of section 1395w–141(i)(1) of this title. Any information disclosed to the Executive Director of the Medicare Payment Advisory Commission or the Executive Director of the Medicaid and CHIP Payment and Access Commission pursuant to this subparagraph shall not be disclosed by either such Executive Director in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler. Such information also shall not be disclosed by either such Executive Director to individual Commissioners of the Medicare Payment Advisory Commission or of the Medicaid and CHIP Payment and Access Commission in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler.

(4) Length of agreement

(A) In general

A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(ii) By a manufacturer

A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

(iv) Notice to States

In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

(v) Application to terminations of other agreements

The provisions of this subparagraph shall apply to the terminations of agreements described in section 256b(a)(1) of this title and master agreements described in section 8126(a) of title 38.

(C) Delay before reentry

In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

(c) Determination of amount of rebate

(1) Basic rebate for single source drugs and innovator multiple source drugs

(A) In general

Except as provided in paragraph (2), the amount of the rebate specified in this subsection for a rebate period (as defined in subsection (k)(8)) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of—

(i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period (as reported by the State); and

(ii) subject to subparagraph (B)(ii), the greater of—

(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

(II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price,

for the rebate period.

(B) Range of rebates required

(i) Minimum rebate percentage

For purposes of subparagraph (A)(ii)(II), the ''minimum rebate percentage'' for rebate periods beginning—

(I) after December 31, 1990, and before October 1, 1992, is 12.5 percent;

(II) after September 30, 1992, and before January 1, 1994, is 15.7 percent;

(III) after December 31, 1993, and before January 1, 1995, is 15.4 percent;

(IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent;

(V) after December 31, 1995, and before January 1, 2010[1] is 15.1 percent; and

(VI) except as provided in clause (iii), after December 31, 2009,[2] 23.1 percent.

(ii) Temporary limitation on maximum rebate amount

In no case shall the amount applied under subparagraph (A)(ii) for a rebate period beginning—

(I) before January 1, 1992, exceed 25 percent of the average manufacturer price; or

(II) after December 31, 1991, and before January 1, 1993, exceed 50 percent of the average manufacturer price.

(iii) Minimum rebate percentage for certain drugs

(I) In general

In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

(II) Drug described

For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

(aa) A clotting factor for which a separate furnishing payment is made under section 1395u(*o*)(5) of this title and which is included on a list of such factors specified and updated regularly by the Secretary.

(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.

(C) "Best price" defined

For purposes of this section—

(i) In general

The term ''best price'' means, with respect to a single source drug or innovator multiple source drug of a manufacturer (including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)]), the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding—

(I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) (including inpatient prices charged to hospitals described in section 256b(a)(4)(L) of this title);

(II) any prices charged under the Federal Supply Schedule of the General Services Administration;

(III) any prices used under a State pharmaceutical assistance program;

(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government;

(V) the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under section 1395w–141 of this title; and

(VI) subject to clause (ii)(V), any prices charged which are negotiated by a prescription drug plan under part D of subchapter XVIII, by an MA–PD plan under part C of such subchapter with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1395w–132(a)(2) of this title) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such subchapter, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1395w–114a of this title or under the manufacturer discount program under section 1395w–114c of this title.

(ii) Special rules

The term ''best price''—

(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section, section 1395w–3a(i) of this title, or section 1395w–114b of this title);

(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package;

(III) shall not take into account prices that are merely nominal in amount[3]

[1] So in original. Probably should be followed by a comma.

[2] So in original. Probably should be followed by ''is''.

[3] So in original. Probably should be followed by a semicolon.

(IV) in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)], shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i); and

(V) in the case of a rebate period and a covered outpatient drug that is a selected drug (as referred to in section 1320f–1(c) of this title) during such rebate period, shall be inclusive of the maximum fair price (as defined in section 1320f(c)(3) of this title) for such drug with respect to such period.

(iii) Application of auditing and recordkeeping requirements

With respect to a covered entity described in section 256b(a)(4)(L) of this title, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 256b(a)(5)(C) of this title.

(D) Limitation on sales at a nominal price

(i) In general

For purposes of subparagraph (C)(ii)(III) and subsection (b)(3)(A)(iii)(III), only sales by a manufacturer of covered outpatient drugs at nominal prices to the following shall be considered to be sales at a nominal price or merely nominal in amount:

(I) A covered entity described in section 256b(a)(4) of this title.

(II) An intermediate care facility for the mentally retarded.

(III) A State-owned or operated nursing facility.

(IV) An entity that—

(aa) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Act or is State-owned or operated; and

(bb) would be a covered entity described in section 256b(a)(4)[4] of this title insofar as the entity provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section;

(V) A public or nonprofit entity, or an entity based at an institution of higher learning whose primary purpose is to provide health care services to students of that institution, that provides a service or services described under section 300(a) of this title.

(VI) Any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at a nominal price would be appropriate based on the factors described in clause (ii).

(ii) Factors

The factors described in this clause with respect to a facility or entity are the following:

(I) The type of facility or entity.

(II) The services provided by the facility or entity.

(III) The patient population served by the facility or entity.

(IV) The number of other facilities or entities eligible to purchase at nominal prices in the same service area.

(iii) Nonapplication

Clause (i) shall not apply with respect to sales by a manufacturer at a nominal price of covered outpatient drugs pursuant to a master agreement under section 8126 of title 38.

(iv) Rule of construction

Nothing in this subparagraph shall be construed to alter any existing statutory or regulatory prohibition on services with respect to an entity described in clause (i)(IV), including the prohibition set forth in section 300a–6 of this title.

(2) Additional rebate for single source and innovator multiple source drugs

(A) In general

The amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of—

(i) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period; and

(ii) the amount (if any) by which—

(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds

(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the consumer price index for all urban consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

(B) Treatment of subsequently approved drugs

In the case of a covered outpatient drug approved by the Food and Drug Administra-

[4] See References in Text note below.

tion after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting ''the first full calendar quarter after the day on which the drug was first marketed'' for ''the calendar quarter beginning July 1, 1990'' and ''the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed'' for ''September 1990''.

(C) Treatment of new formulations

(i) In general

In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation for a rebate period with respect to such drug under this subsection shall be the greater of the amount described in clause (ii) for such drug or the amount described in clause (iii) for such drug.

(ii) Amount 1

For purposes of clause (i), the amount described in this clause with respect to a drug described in clause (i) and rebate period is the amount computed under paragraph (1) for such drug, increased by the amount computed under subparagraph (A) and, as applicable, subparagraph (B) for such drug and rebate period.

(iii) Amount 2

For purposes of clause (i), the amount described in this clause with respect to a drug described in clause (i) and rebate period is the amount computed under paragraph (1) for such drug, increased by the product of—

(I) the average manufacturer price for the rebate period of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this paragraph for the rebate period for any strength of the original single source drug or innovator multiple source drug; and

(III) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).

In this subparagraph, the term ''line extension'' means, with respect to a drug, a new formulation of the drug, such as an extended release formulation, but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation.

(D) Maximum rebate amount

In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, and before January 1, 2024, exceed 100 percent of the average manufacturer price of the drug.

(3) Rebate for other drugs

(A) In general

Except as provided in subparagraph (C), the amount of the rebate paid to a State for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period, and

(ii) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period.

(B) "Applicable percentage" defined

For purposes of subparagraph (A)(i), the ''applicable percentage'' for rebate periods beginning—

(i) before January 1, 1994, is 10 percent,

(ii) after December 31, 1993, and before January 1, 2010, is 11 percent;[5] and

(iii) after December 31, 2009, is 13 percent.

(C) Additional rebate

(i) In general

The amount of the rebate specified in this paragraph for a rebate period, with respect to each dosage form and strength of a covered outpatient drug other than a single source drug or an innovator multiple source drug of a manufacturer, shall be increased in the manner that the rebate for a dosage form and strength of a single source drug or an innovator multiple source drug is increased under subparagraphs (A) and (D) of paragraph (2), except as provided in clause (ii).

(ii) Special rules for application of provision

In applying subparagraphs (A) and (D) of paragraph (2) under clause (i)—

(I) the reference in subparagraph (A)(i) of such paragraph to ''1990'' shall be deemed a reference to ''2014'';

(II) subject to clause (iii), the reference in subparagraph (A)(ii) of such paragraph to ''the calendar quarter beginning July 1, 1990'' shall be deemed a reference to ''the calendar quarter beginning July 1, 2014''; and

(III) subject to clause (iii), the reference in subparagraph (A)(ii) of such paragraph to ''September 1990'' shall be deemed a reference to ''September 2014'';

(IV) the references in subparagraph (D) of such paragraph to ''paragraph (1)(A)(ii)'', ''this paragraph'', and ''December 31, 2009'' shall be deemed references to ''subparagraph (A)'', ''this subparagraph'', and ''December 31, 2014'', respectively; and

(V) any reference in such paragraph to a ''single source drug or an innovator

[5] So in original. The semicolon probably should be a comma.

multiple source drug'' shall be deemed to be a reference to a drug to which clause (i) applies.

(iii) Special rule for certain noninnovator multiple source drugs

In applying paragraph (2)(A)(ii)(II) under clause (i) with respect to a covered outpatient drug that is first marketed as a drug other than a single source drug or an innovator multiple source drug after April 1, 2013, such paragraph shall be applied—

(I) by substituting ''the applicable quarter'' for ''the calendar quarter beginning July 1, 1990''; and

(II) by substituting ''the last month in such applicable quarter'' for ''September 1990''.

(iv) Applicable quarter defined

In this subsection, the term ''applicable quarter'' means, with respect to a drug described in clause (iii), the fifth full calendar quarter after which the drug is marketed as a drug other than a single source drug or an innovator multiple source drug.

(4) Recovery of unpaid rebate amounts due to misclassification of covered outpatient drugs

(A) In general

If the Secretary determines that a manufacturer with an agreement under this section paid a lower per-unit rebate amount to a State for a rebate period as a result of the misclassification by the manufacturer of a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made) than the per-unit rebate amount that the manufacturer would have paid to the State if the drug had been correctly classified, the manufacturer shall pay to the State an amount equal to the product of—

(i) the difference between—

(I) the per-unit rebate amount paid to the State for the period; and

(II) the per-unit rebate amount that the manufacturer would have paid to the State for the period, as determined by the Secretary, if the drug had been correctly classified; and

(ii) the total units of the drug paid for under the State plan in the period.

(B) Authority to correct misclassifications

(i) In general

If the Secretary determines that a manufacturer with an agreement under this section has misclassified a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made), the Secretary shall notify the manufacturer of the misclassification and require the manufacturer to correct the misclassification in a timely manner.

(ii) Enforcement

If, after receiving notice of a misclassification from the Secretary under clause (i), a manufacturer fails to correct the misclassification by such time as the Secretary shall require, until the manufacturer makes such correction, the Secretary may do any or all of the following:

(I) Correct the misclassification, using drug product information provided by the manufacturer, on behalf of the manufacturer.

(II) Suspend the misclassified drug and the drug's status as a covered outpatient drug under the manufacturer's national rebate agreement, and exclude the misclassified drug from Federal financial participation in accordance with section 1396b(i)(10)(E) of this title.

(III) Impose a civil money penalty (which shall be in addition to any other recovery or penalty which may be available under this section or any other provision of law) for each rebate period during which the drug is misclassified not to exceed an amount equal to the product of—

(aa) the total number of units of each dosage form and strength of such misclassified drug paid for under any State plan during such a rebate period; and

(bb) 23.1 percent of the average manufacturer price for the dosage form and strength of such misclassified drug.

(C) Reporting and transparency

(i) In general

The Secretary shall submit a report to Congress on at least an annual basis that includes information on the covered outpatient drugs that have been identified as misclassified, any steps taken to reclassify such drugs, the actions the Secretary has taken to ensure the payment of any rebate amounts which were unpaid as a result of such misclassification, and a disclosure of expenditures from the fund created in subsection (b)(3)(C)(iv), including an accounting of how such funds have been allocated and spent in accordance with such subsection.

(ii) Public access

The Secretary shall make the information contained in the report required under clause (i) available to the public on a timely basis.

(D) Other penalties and actions

Actions taken and penalties imposed under this clause shall be in addition to other remedies available to the Secretary including terminating the manufacturer's rebate agreement for noncompliance with the terms of such agreement and shall not exempt a manufacturer from, or preclude the Secretary from pursuing, any civil money penalty under this subchapter or subchapter XI, or any other penalty or action as may be prescribed by law.

(d) Limitations on coverage of drugs

(1) Permissible restrictions

(A) A State may subject to prior authorization any covered outpatient drug. Any such

prior authorization program shall comply with the requirements of paragraph (5).

(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

(i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6));

(ii) the drug is contained in the list referred to in paragraph (2);

(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4); or

(iv) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

(2) List of drugs subject to restriction

The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia, weight loss, or weight gain.

(B) Agents when used to promote fertility.

(C) Agents when used for cosmetic purposes or hair growth.

(D) Agents when used for the symptomatic relief of cough and colds.

(E) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(F) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title, agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(G) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(H) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(3) Update of drug listings

The Secretary shall, by regulation, periodically update the list of drugs or classes of drugs described in paragraph (2) or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

(4) Requirements for formularies

A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3)).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] but is a medically accepted indication, based on information from the appropriate compendia described in subsection (k)(6)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The State plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) Requirements of prior authorization programs

A State plan under this subchapter may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) only if the system providing for such approval—

(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) Other permissible restrictions

A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this chapter.

(7) Non-excludable drugs

The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(B) Barbiturates.

(C) Benzodiazepines.

(D) Drugs and biological products described in subsection (ee)(1)(A) of section 1396d of this title that are furnished as medical assistance in accordance with subsection (a)(29) of such section and section 1396a(a)(10)(A) of this title.

(E) Drugs and biological products to which section 1396d(a)(4)(F) of this title and subclause (XVIII) in the matter following subparagraph (G) of section 1396a(a)(10) of this title apply that are furnished as medical assistance in accordance with such section or clause, respectively, for the treatment or prevention, of COVID–19, as described in such subparagraph or subclause, respectively, and section 1396a(a)(10)(A) of this title.

(e) Treatment of pharmacy reimbursement limits

(1) In general

During the period beginning on January 1, 1991, and ending on December 31, 1994—

(A) a State may not reduce the payment limits established by regulation under this subchapter or any limitation described in paragraph (3) with respect to the ingredient cost of a covered outpatient drug or the dispensing fee for such a drug below the limits in effect as of January 1, 1991, and

(B) except as provided in paragraph (2), the Secretary may not modify by regulation the formula established under sections 447.331 through 447.334 of title 42, Code of Federal Regulations, in effect on November 5, 1990, to reduce the limits described in subparagraph (A).

(2) Special rule

If a State is not in compliance with the regulations described in paragraph (1)(B), paragraph (1)(A) shall not apply to such State until such State is in compliance with such regulations.

(3) Effect on State maximum allowable cost limitations

This section shall not supersede or affect provisions in effect prior to January 1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.

[(4)][6] Establishment of upper payment limits

Subject to paragraph (5), the Secretary shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

(5) Use of amp in upper payment limits

The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1395w–3a of this title.

(f) Survey of retail prices; State payment and utilization rates; and performance rankings

(1) Survey of retail prices

(A) Use of vendor

The Secretary may contract services for—

(i) with respect to a retail community pharmacy, the determination on a monthly basis of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available); and

(ii) the notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available.

(B) Secretary response to notification of availability of multiple source products

If contractor notifies the Secretary under subparagraph (A)(ii) that a drug product described in such subparagraph has become generally available, the Secretary shall make a determination, within 7 days after receiving such notification, as to whether the product is now described in subsection (e)(4).[4]

(C) Use of competitive bidding

In contracting for such services, the Secretary shall competitively bid for an outside vendor that has a demonstrated history in—

(i) surveying and determining, on a representative nationwide basis, retail prices for ingredient costs of prescription drugs;

(ii) working with retail community pharmacies, commercial payers, and States in obtaining and disseminating such price information; and

(iii) collecting and reporting such price information on at least a monthly basis.

In contracting for such services, the Secretary may waive such provisions of the Fed-

[6] See 1993 Amendment note below.

eral Acquisition Regulation as are necessary for the efficient implementation of this subsection, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Additional provisions

A contract with a vendor under this paragraph shall include such terms and conditions as the Secretary shall specify, including the following:

(i) The vendor must monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug generally available.

(ii) The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs.

(iii) The contract shall be effective for a term of 2 years.

(E) Availability of information to States

Information on retail survey prices obtained under this paragraph, including applicable information on single source drugs, shall be provided to States on at least a monthly basis. The Secretary shall devise and implement a means for providing access to each State agency designated under section 1396a(a)(5) of this title with responsibility for the administration or supervision of the administration of the State plan under this subchapter of the retail survey price determined under this paragraph.

(2) Annual State report

Each State shall annually report to the Secretary information on—

(A) the payment rates under the State plan under this subchapter for covered outpatient drugs;

(B) the dispensing fees paid under such plan for such drugs; and

(C) utilization rates for noninnovator multiple source drugs under such plan.

(3) Annual State performance rankings

(A) Comparative analysis

The Secretary annually shall compare, for the 50 most widely prescribed drugs identified by the Secretary, the national retail sales price data (collected under paragraph (1)) for such drugs with data on prices under this subchapter for each such drug for each State.

(B) Availability of information

The Secretary shall submit to Congress and the States full information regarding the annual rankings made under subparagraph (A).

(4) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services $5,000,000 for each of fiscal years 2006 through 2010 to carry out this subsection.

(g) Drug use review

(1) In general

(A) In order to meet the requirement of section 1396a(a)(54) of this title, a State shall provide for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information (or its successor publications); and

(III) the DRUGDEX Information System; and

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in section 1396b of this title, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1396r of this title, currently at section 483.60 of title 42, Code of Federal Regulations.

(2) Description of program

Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) Prospective drug review

(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this subchapter, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with non-

prescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this subchapter by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this subchapter or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this subchapter:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individual's drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this subchapter or caregiver of such individual refuses such consultation, or to require verification of the offer to provide consultation or a refusal of such offer.

(B) Retrospective drug use review

The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1396b(r) of this title) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization, among physicians, pharmacists and individuals receiving benefits under this subchapter, or associated with specific drugs or groups of drugs.

(C) Application of standards

The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection[7] (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

(D) Educational program

The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

(3) State drug use review board

(A) Establishment

Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the ''DUR Board'') either directly or through a contract with a private organization.

(B) Membership

The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of covered outpatient drugs.

(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

(iii) Drug use review, evaluation, and intervention.

[7] So in original. Probably should be ''paragraph''.

(iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least ⅓ but no more than 51 percent licensed and actively practicing physicians and at least ⅓ * * *[8] licensed and actively practicing pharmacists.

(C) Activities

The activities of the DUR Board shall include but not be limited to the following:

(i) Retrospective DUR as defined in section[7] (2)(B).

(ii) Application of standards as defined in section[7] (2)(C).

(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

(D) Annual report

Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

[8] So in original.

(h) Electronic claims management

(1) In general

In accordance with chapter 35 of title 44 (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this subchapter, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

(2) Encouragement

In order to carry out paragraph (1)—

(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1396b(a)(3)(A)(i) of this title (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

(i) Omitted

(j) Exemption of organized health care settings

(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1396b(m) of this title; and

(B) subject to discounts under section 256b of this title.

(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

(k) Definitions

In this section—

(1) Average manufacturer price

(A) In general

Subject to subparagraph (B), the term ''average manufacturer price'' means, with re-

spect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by—

(i) wholesalers for drugs distributed to retail community pharmacies; and

(ii) retail community pharmacies that purchase drugs directly from the manufacturer.

(B) Exclusion of customary prompt pay discounts and other payments

(i) In general

The average manufacturer price for a covered outpatient drug shall exclude—

(I) customary prompt pay discounts extended to wholesalers;

(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy, unless the drug is an inhalation, infusion, instilled, implanted, or injectable drug that is not generally dispensed through a retail community pharmacy[3]

(V) discounts provided by manufacturers under section 1395w–114a of this title or under section 1395w–114c of this title;

(VI) any reduction in price paid during the rebate period to the manufacturer for a drug by reason of application of part E of subchapter XI;

(VII) rebates paid by manufacturers under section 1395w–3a(i) of this title; and

(VIII) rebates paid by manufacturers under section 1395w–114b of this title.

(ii) Inclusion of other discounts and payments

Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.

(C) Exclusion of section 505(c) drugs

In the case of a manufacturer that approves, allows, or otherwise permits any drug of the manufacturer to be sold under the manufacturer's new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)], such term shall be exclusive of the average price paid for such drug by wholesalers for drugs distributed to retail community pharmacies.

(2) Covered outpatient drug

Subject to the exceptions in paragraph (3), the term ''covered outpatient drug'' means—

(A) of those drugs which are treated as prescribed drugs for purposes of section 1396d(a)(12) of this title, a drug which may be dispensed only upon prescription (except as provided in paragraph (4)), and—

(i) which is approved for safety and effectiveness as a prescription drug under section 505 [21 U.S.C. 355] or 507[4] of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act [21 U.S.C. 355(j)];

(ii)(I) which was commercially used or sold in the United States before October 10, 1962, or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a ''new drug'' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 321(p)]) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act [21 U.S.C. 331, 332(a), 334(a)] to enforce section 502(f) or 505(a) of such Act [21 U.S.C. 352(f), 355(a)]; or

(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(e)] on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which—

(i) may only be dispensed upon prescription,

(ii) is licensed under section 262 of this title, and

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506[4] of the Federal Food, Drug, and Cosmetic Act.

(3) Limiting definition

The term ''covered outpatient drug'' does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this subchapter as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians' services.

(E) Outpatient hospital services.

(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological[9] used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.

(4) Nonprescription drugs

If a State plan for medical assistance under this subchapter includes coverage of prescribed drugs as described in section 1396d(a)(12) of this title and permits coverage of drugs which may be sold without a prescription (commonly referred to as ''over-the-counter'' drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

(5) Manufacturer

The term ''manufacturer'' means any entity which is engaged in—

(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Medically accepted indication

The term ''medically accepted indication'' means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i).

(7) Multiple source drug; innovator multiple source drug; noninnovator multiple source drug; single source drug

(A) Defined

(i) Multiple source drug

The term ''multiple source drug'' means, with respect to a rebate period, a covered outpatient drug, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4), for which there[2] at least 1 other drug product which—

(I) is rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of ''Approved Drug Products with Therapeutic Equivalence Evaluations''),

(II) except as provided in subparagraph (B), is pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

(III) is sold or marketed in the United States during the period.

(ii) Innovator multiple source drug

The term ''innovator multiple source drug'' means a multiple source drug that is marketed under a new drug application approved by the Food and Drug Administration, unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation)).

(iii) Noninnovator multiple source drug

The term ''noninnovator multiple source drug'' means a multiple source drug that is not an innovator multiple source drug.

(iv) Single source drug

The term ''single source drug'' means a covered outpatient drug, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4), which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation)). Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration.

(B) Exception

Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes

[9] So in original. Probably should be ''biological product''.

by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

(C) Definitions

For purposes of this paragraph—

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

(8) Rebate period

The term ''rebate period'' means, with respect to an agreement under subsection (a), a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.

(9) State agency

The term ''State agency'' means the agency designated under section 1396a(a)(5) of this title to administer or supervise the administration of the State plan for medical assistance.

(10) Retail community pharmacy

The term ''retail community pharmacy'' means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

(11) Wholesaler

The term ''wholesaler'' means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.

(Aug. 14, 1935, ch. 531, title XIX, § 1927, as added Pub. L. 101–508, title IV, § 4401(a)(3), Nov. 5, 1990, 104 Stat. 1388–143; amended Pub. L. 102–585, title VI, § 601(a)–(c), Nov. 4, 1992, 106 Stat. 4962–4964; Pub. L. 103–18, § 2(a), Apr. 12, 1993, 107 Stat. 54; Pub. L. 103–66, title XIII, § 13602(a), Aug. 10, 1993, 107 Stat. 613; Pub. L. 105–33, title IV, §§ 4701(b)(2)(A)(x), 4756, Aug. 5, 1997, 111 Stat. 493, 527; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, §§ 606(a), 608(u)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, 1501A–398; Pub. L. 108–173, title I, §§ 101(e)(4), (9), 103(e)(1), 105(b), title III, § 303(i)(4), title IX, § 900(e)(1)(K), (L), title X, § 1002, Dec. 8, 2003, 117 Stat. 2151, 2152, 2159, 2166, 2254, 2372, 2431; Pub. L. 109–91, title I, § 104(a), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109–171, title VI, §§ 6001(a)–(c)(2), (d)–(f)(2), 6002(a), 6003(a), (b), 6004(a), Feb. 8, 2006, 120 Stat. 54–61; Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(ii), Dec. 20, 2006, 120 Stat. 3000; Pub. L. 111–8, div. F, title II, § 221(a), Mar. 11, 2009, 123 Stat. 783; Pub. L. 111–148, title II, §§ 2501(a), (b), (c)(2), (d)(1), (e), 2502(a), 2503(a)–(c), title III, § 3301(d)(2), title IV, § 4107(b), Mar. 23, 2010, 124 Stat. 306–310, 312, 468, 560; Pub. L. 111–152, title I, §§ 1101(c), 1206(a), Mar. 30, 2010, 124 Stat. 1039, 1056; Pub. L. 111–226, title II, § 202, Aug. 10, 2010, 124 Stat. 2394; Pub. L. 111–309, title II, § 204(b), Dec. 15, 2010, 124 Stat. 3290; Pub. L. 114–74, title VI, § 602(a), Nov. 2, 2015, 129 Stat. 596; Pub. L. 114–198, title VII, § 705(a), July 22, 2016, 130 Stat. 753; Pub. L. 115–123, div. E, title XII, § 53104(a), Feb. 9, 2018, 132 Stat. 302; Pub. L. 115–271, title I, § 1004(b)(1), Oct. 24, 2018, 132 Stat. 3912; Pub. L. 116–16, § 6(a)(1), (2)(B)–(c), Apr. 18, 2019, 133 Stat. 859, 861, 863; Pub. L. 116–59, div. B, title VI, § 1603(a), (b), Sept. 27, 2019, 133 Stat. 1108; Pub. L. 116–159, div. C, title VI, § 2601(b), Oct. 1, 2020, 134 Stat. 738; Pub. L. 116–260, div. CC, title I, § 112(b), title IV, § 401(c), Dec. 27, 2020, 134 Stat. 2947, 2997; Pub. L. 117–2, title IX, §§ 9811(a)(4)(B), 9816, Mar. 11, 2021, 135 Stat. 210, 216; Pub. L. 117–169, title I, §§ 11001(b)(1)(G)(ii), (2), (3), 11002(b), 11101(c)(2)–(4), 11102(b)(2)–(4), 11201(e)(8), Aug. 16, 2022, 136 Stat. 1853, 1854, 1862, 1870, 1876, 1877, 1892.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3) and (c)(1)(D)(i)(IV)(aa), is classified generally to Title 26, Internal Revenue Code.

The amendments made by subsections (a)(1), (b), (c), and (d) of section 2501 of the Patient Protection and Affordable Care Act, referred to in subsec. (b)(1)(C)(i)(II), mean the amendments made by section 2501(a)(1), (b), (c), and (d) of Pub. L. 111–148, which amended this section and section 1396b of this title.

Section 256b(a)(4) of this title, referred to in subsec. (c)(1)(D)(i)(IV)(bb), was in the original ''section 340(B)(a)(4) of the Public Health Service Act'', and was translated as meaning section 340B(a)(4) of the Public Health Service Act, which defines ''covered entity'', to reflect the probable intent of Congress.

The Federal Food, Drug, and Cosmetic Act, referred to in subsecs. (d)(4)(C) and (k)(6), is act June 25, 1938, ch. 675, 52 Stat. 1040, which is classified generally to chapter 9 (§ 301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

Paragraph (4) and subsection (e)(4), referred to in subsecs. (e)(5) and (f)(1)(B), probably means text that was editorially designated as par. (4) of subsec. (e). See 1993 Amendment note below.

Section 507 of the Federal Food, Drug, and Cosmetic Act, referred to in subsec. (k)(2)(A)(i), was repealed by Pub. L. 105–115, title I, § 125(b)(1), Nov. 21, 1997, 111 Stat. 2325.

Section 107(c)(3) of the Drug Amendments of 1962, referred to in subsec. (k)(2)(A)(iii)(I), is section 107(c)(3) of

Pub. L. 87–781 which is set out in an Effective Date of 1962 Amendment note under section 321 of Title 21, Food and Drugs.

Section 506 of the Federal Food, Drug, and Cosmetic Act, referred to in subsec. (k)(2)(C), was repealed and a new section 506 enacted by Pub. L. 105–115, title I, §§112(a), 125(a)(1), Nov. 21, 1997, 111 Stat. 2309, 2325, which no longer relates to insulin.

CODIFICATION

Subsec. (i) of this section, which required the Secretary to transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives an annual report on the operation of this section in the preceding fiscal year, terminated, effective May 15, 2000, pursuant to section 3003 of Pub. L. 104–66, set out as a note under section 1113 of Title 31, Money and Finance. See, also, item 9 on page 93 of House Document No. 103–7.

PRIOR PROVISIONS

A prior section 1927 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2022—Subsec. (a)(3). Pub. L. 117–169, §11001(b)(1)(G)(ii), inserted at end ''The preceding sentence shall not apply to a single source drug or innovator multiple source drug of a manufacturer for any period described in section 5000D(c)(1) of the Internal Revenue Code of 1986 with respect to the manufacturer.''

Subsec. (b)(3)(D)(i). Pub. L. 117–169, §11102(b)(3), substituted '', section 1320f–1(f) of this title, including rebates under paragraph (4) of such section, or section 1395w–114b of this title'' for ''or section 1320f–1(f) of this title, including rebates under paragraph (4) of such section''.

Pub. L. 117–169, §11101(c)(3), inserted ''and the rebate'' after ''the payment amount''.

Pub. L. 117–169, §11002(b), substituted ''or to carry out section 1395w–3b of this title or section 1320f–1(f) of this title, including rebates under paragraph (4) of such section'' for ''or to carry out section 1395w–3b of this title''.

Subsec. (c)(1)(C)(i)(VI). Pub. L. 117–169, §11201(e)(8)(A), inserted before period at end ''or under the manufacturer discount program under section 1395w–114c of this title''.

Pub. L. 117–169, §11001(b)(2)(A), substituted ''subject to clause (ii)(V), any prices charged'' for ''any prices charged''.

Subsec. (c)(1)(C)(ii)(I). Pub. L. 117–169, §11102(b)(2), substituted '', section 1395w–3a(i) of this title, or section 1395w–114b of this title'' for ''or section 1395w–3a(i) of this title''.

Pub. L. 117–169, §11101(c)(2), inserted ''or section 1395w–3a(i) of this title'' after ''this section''.

Subsec. (c)(1)(C)(ii)(V). Pub. L. 117–169, §11001(b)(2)(B), added subcl. (V).

Subsec. (k)(1)(B)(i)(V). Pub. L. 117–169, §11201(e)(8)(B), inserted before period at end ''or under section 1395w–114c of this title''.

Subsec. (k)(1)(B)(i)(VI). Pub. L. 117–169, §11001(b)(3), added subcl. (VI).

Subsec. (k)(1)(B)(i)(VII). Pub. L. 117–169, §11101(c)(4), added subcl. (VII).

Subsec. (k)(1)(B)(i)(VIII). Pub. L. 117–169, §11102(b)(4), added subcl. (VIII). Conforming amendments striking ''and'' at the end of subcl. (VI) and substituting semicolon for period at the end of subcl. (VII) could not be executed as directed after the amendment by Pub. L. 117–169, §11101(c)(4)(B), (C).

2021—Subsec. (c)(2)(D). Pub. L. 117–2, §9816, inserted ''and before January 1, 2024,'' after ''December 31, 2009,''.

Subsec. (d)(7)(E). Pub. L. 117–2, §9811(a)(4)(B), added subpar. (E).

2020—Subsec. (b)(3)(A). Pub. L. 116–260, §401(c)(1), inserted at end of concluding provisions ''For purposes of applying clause (iii), for calendar quarters beginning on or after January 1, 2022, a drug or biological described in the flush matter following such clause includes items, services, supplies, and products that are payable under part B of subchapter XVIII as a drug or biological.''

Subsec. (b)(3)(A)(iii). Pub. L. 116–260, §401(c)(2), substituted ''section 1395rr(b)(14)(B) of this title'' for ''section 1395rr(b)(13)(A)(ii) of this title'' in concluding provisions.

Subsec. (b)(3)(D). Pub. L. 116–260, §112(b)(5), (6), in concluding provisions, substituted ''1395w–104(c)(2)(G) of this title'' for ''1395w–104(c)(2)(E) of this title'' and inserted at end ''Any information disclosed to the Executive Director of the Medicare Payment Advisory Commission or the Executive Director of the Medicaid and CHIP Payment and Access Commission pursuant to this subparagraph shall not be disclosed by either such Executive Director in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler. Such information also shall not be disclosed by either such Executive Director to individual Commissioners of the Medicare Payment Advisory Commission or of the Medicaid and CHIP Payment and Access Commission in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler.''

Pub. L. 116–260, §112(b)(1), substituted ''subsection (a)(6)(A)'' for ''subsection (a)(6)(A)(ii)'' in introductory provisions.

Subsec. (b)(3)(D)(vii). Pub. L. 116–260, §112(b)(2)–(4), added cl. (vii).

Subsec. (d)(7)(D). Pub. L. 116–159 added subpar. (D).

2019—Subsec. (b)(1)(B). Pub. L. 116–16, §6(b)(2), inserted '', including amounts received by a State under subsection (c)(4),'' after ''in any quarter''.

Subsec. (b)(3). Pub. L. 116–16, §6(a)(1)(A), inserted ''and drug product'' after ''price'' in heading.

Subsec. (b)(3)(A)(ii), (iii). Pub. L. 116–16, §6(a)(1)(B)(i), (ii), struck out ''and'' at end of cl. (ii) and substituted semicolon for period at end of cl. (iii).

Subsec. (b)(3)(A)(v). Pub. L. 116–16, §6(a)(1)(B)(iii), (iv), added cl. (v).

Subsec. (b)(3)(C)(ii). Pub. L. 116–16, §6(a)(1)(C)(i), (2)(B), inserted '', including information related to drug pricing, drug product information, and data related to drug pricing or drug product information,'' after ''provides false information'' and substituted ''subsections (a), (b), (f)(3), and (f)(4)'' for ''subsections (a) and (b)''.

Subsec. (b)(3)(C)(iii), (iv). Pub. L. 116–16, §6(a)(1)(C)(ii), added cls. (iii) and (iv).

Subsec. (b)(3)(D)(vi). Pub. L. 116–16, §6(a)(1)(C)(iii), added cl. (vi).

Subsec. (c)(4). Pub. L. 116–16, §6(b)(1), added par. (4).

Subsec. (k)(1)(C). Pub. L. 116–59, §1603(a), substituted ''Exclusion'' for ''Inclusion'' in heading and ''the manufacturer's new drug application'' for ''a new drug application'' and ''exclusive'' for ''inclusive'' in text.

Subsec. (k)(2)(A). Pub. L. 116–16, §6(c)(1), substituted ''paragraph (4)'' for ''paragraph (5)'' in introductory provisions.

Subsec. (k)(7)(A)(i). Pub. L. 116–16, §6(c)(2)(B), substituted '', including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4),'' for ''(not including any drug described in paragraph (5))''.

Subsec. (k)(7)(A)(ii). Pub. L. 116–16, §6(c)(2)(A), (C), substituted ''is marketed'' for ''was originally marketed'' and ''a new drug application'' for ''an original new drug application'' and inserted '', unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation))'' before period at end.

Subsec. (k)(7)(A)(iv). Pub. L. 116–16, §6(c)(2)(A), (D), substituted ''a new drug application'' for ''an original

new drug application'' and inserted '', including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4),'' after ''covered outpatient drug'', ''unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation))'' after ''under the new drug application'', and ''Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration.'' at end.

Subsec. (k)(11). Pub. L. 116–59, § 1603(b), struck out ''manufacturers,'' before ''repackers,'' and ''manufacturer's and'' before ''distributor's warehouses,''.

2018—Subsec. (c)(2)(C). Pub. L. 115–123 added cls. (i) to (iii) and struck out introductory provisions and former cls. (i) to (iii) which read as follows: ''In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

''(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

''(ii) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(iii) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).''

Subsec. (g)(1)(A). Pub. L. 115–271, § 1004(b)(1)(A), substituted ''of section 1396a(a)(54)'' for ''of section 1396b(i)(10)(B)'', struck out '', by not later than January 1, 1993,'' after ''shall provide'', and substituted ''gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization'' for ''gross overuse, or inappropriate or medically unnecessary care''.

Subsec. (g)(2)(B). Pub. L. 115–271, § 1004(b)(1)(B), substituted ''gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization'' for ''gross overuse, or inappropriate or medically unnecessary care''.

2016—Subsec. (c)(2)(C). Pub. L. 114–198 inserted before period at end of concluding provisions '', but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation''.

2015—Subsec. (c)(3)(A). Pub. L. 114–74, § 602(a)(1), substituted ''Except as provided in subparagraph (C), the amount'' for ''The amount''.

Subsec. (c)(3)(C). Pub. L. 114–74, § 602(a)(2), added subpar. (C).

2010—Subsec. (a)(5)(B). Pub. L. 111–309 substituted a period for ''and a children's hospital described in section 1395ww(d)(1)(B)(iii) of this title which meets the requirements of clauses (i) and (iii) of section 256b(b)(4)(L) of this title and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for medical assistance under a State plan under this subchapter.''

Subsec. (b)(1)(A). Pub. L. 111–148, § 2501(c)(2)(A)(i), inserted '', including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs'' after ''for such period''.

Subsec. (b)(1)(C). Pub. L. 111–148, § 2501(a)(2), added subpar. (C).

Subsec. (b)(2)(A). Pub. L. 111–148, § 2501(c)(2)(A)(ii), inserted ''including such information reported by each medicaid managed care organization,'' after ''for which payment was made under the plan during the period,''.

Subsec. (b)(3)(A). Pub. L. 111–148, § 2503(b)(1)(B), which directed insertion, in the second sentence, of ''(relating to the weighted average of the most recently reported monthly average manufacturer prices)'' after ''(D)(v)'' was executed by making the insertion in concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(3)(A)(iv). Pub. L. 111–148, § 2503(b)(1)(A), which directed, in the first sentence, addition of cl. (iv) after cl. (iii), was executed by adding cl. (iv) after cl. (iii) to reflect the probable intent of Congress.

Subsec. (b)(3)(D)(v). Pub. L. 111–148, § 2503(b)(2), substituted ''the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)'' for ''average manufacturer prices''.

Subsec. (c)(1)(B)(i)(IV) to (VI). Pub. L. 111–148, § 2501(a)(1)(A), struck out ''and'' at end of subcl. (IV), inserted ''and before January 1, 2010'' after ''December 31, 1995,'' and substituted ''; and'' for period at end in subcl. (V), and added subcl. (VI).

Subsec. (c)(1)(B)(iii). Pub. L. 111–148, § 2501(a)(1)(B), added cl. (iii).

Subsec. (c)(1)(C)(i)(VI). Pub. L. 111–148, § 3301(d)(2), inserted '', or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1395w–114a of this title'' before period at end.

Subsec. (c)(2)(C). Pub. L. 111–152, § 1206(a), amended subpar. (C) generally. Prior to amendment, text read as follows:

''(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

''(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

''(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

''(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.''

Pub. L. 111–148, § 2501(d)(1), added subpar. (C).

Subsec. (c)(2)(D). Pub. L. 111–148, § 2501(e), added subpar. (D).

Subsec. (c)(3)(B). Pub. L. 111–148, § 2501(b), struck out ''and'' at end of cl. (i), inserted ''and before January 1, 2010,'' after ''December 31, 1993,'' and substituted ''; and'' for period at end in cl. (ii), and added cl. (iii).

Subsec. (d)(2)(E). Pub. L. 111–148, § 2502(a)(1), redesignated subpar. (F) as (E) and struck out former subpar. (E) which read as follows: ''Agents when used to promote smoking cessation.''

Subsec. (d)(2)(F). Pub. L. 111–148, § 4107(b), inserted '', except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title, agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation'' before period at end.

Pub. L. 111–148, § 2502(a)(1)(B), redesignated subpar. (G) as (F). Former subpar. (F) redesignated (E).

Subsec. (d)(2)(G) to (K). Pub. L. 111–148, § 2502(a)(1), redesignated subpars. (H) and (K) as (G) and (H), respectively, and struck out subpars. (I) and (J) which read as follows:

''(I) Barbiturates.

''(J) Benzodiazepines.''

Subsec. (d)(7). Pub. L. 111–148, § 2502(a)(2), added par. (7).

Subsec. (e)(4). Pub. L. 111–148, § 2503(a)(1)(A), struck out ''(or, effective January 1, 2007, two or more)'' after ''three or more''.

Subsec. (e)(5). Pub. L. 111–148, § 2503(a)(1)(B), added par. (5) and struck out former par. (5). Prior to amendment, text read as follows: ''Effective January 1, 2007, in applying the Federal upper reimbursement limit under paragraph (4) and section 447.332(b) of title 42 of the Code of Federal Regulations, the Secretary shall substitute 250 percent of the average manufacturer price (as computed without regard to customary prompt pay discounts extended to wholesalers) for 150 percent of the published price.''

Subsec. (f)(1)(A)(i). Pub. L. 111–148, § 2503(c)(1), inserted ''with respect to a retail community pharmacy,'' before ''the determination''.

Subsec. (f)(1)(C)(ii). Pub. L. 111–148, § 2503(c)(2), substituted ''retail community pharmacies'' for ''retail pharmacies''.

Subsec. (j)(1). Pub. L. 111–148, § 2501(c)(2)(B), added par. (1) and struck out former par. (1) which read as follows: ''Covered outpatient drugs dispensed by health maintenance organizations, including medicaid managed care organizations that contract under section 1396b(m) of this title, are not subject to the requirements of this section.''

Subsec. (k)(1)(A). Pub. L. 111–148, § 2503(a)(2)(A), substituted ''by—'' for ''by wholesalers for drugs distributed to the retail pharmacy class of trade.'' and added cls. (i) and (ii).

Subsec. (k)(1)(B). Pub. L. 111–148, § 2503(a)(2)(B), added subpar. (B) and struck out former subpar. (B). Prior to amendment, text read as follows: ''The average manufacturer price for a covered outpatient drug shall be determined without regard to customary prompt pay discounts extended to wholesalers.''

Subsec. (k)(1)(B)(i)(IV). Pub. L. 111–226 inserted at end '', unless the drug is an inhalation, infusion, instilled, implanted, or injectable drug that is not generally dispensed through a retail community pharmacy; and''.

Subsec. (k)(1)(B)(i)(V). Pub. L. 111–152, § 1101(c), added subcl. (V).

Subsec. (k)(1)(C). Pub. L. 111–148, § 2503(a)(2)(C), substituted ''retail community pharmacies'' for ''the retail pharmacy class of trade''.

Subsec. (k)(7)(A)(i)(III). Pub. L. 111–148, § 2503(a)(3)(A), substituted ''the United States'' for ''the State''.

Subsec. (k)(7)(C). Pub. L. 111–148, § 2503(a)(3)(B), inserted ''and'' after semicolon at end of cl. (i), substituted period for ''; and'' at end of cl. (ii), and struck out cl. (iii) which read as follows: ''a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.''

Subsec. (k)(10), (11). Pub. L. 111–148, § 2503(a)(4), added pars. (10) and (11).

2009—Subsec. (c)(1)(D)(i)(IV) to (VI). Pub. L. 111–8, § 221(a)(1), added subcls. (IV) and (V) and redesignated former subcl. (IV) as (VI).

Subsec. (c)(1)(D)(iv). Pub. L. 111–8, § 221(a)(2), added cl. (iv).

2006—Subsec. (a)(5)(B). Pub. L. 109–171, § 6004(a), inserted before period at end ''and a children's hospital described in section 1395ww(d)(1)(B)(iii) of this title which meets the requirements of clauses (i) and (iii) of section 256b(b)(4)(L) of this title and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for medical assistance under a State plan under this subchapter''.

Subsec. (a)(7). Pub. L. 109–171, § 6002(a), added par. (7).

Subsec. (b)(3)(A). Pub. L. 109–171, § 6001(b)(1)(B), inserted ''Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v).'' at end of concluding provisions.

Subsec. (b)(3)(A)(i). Pub. L. 109–171, § 6003(a)(1), added cl. (i) and struck out former cl. (i) which read as follows: ''not later than 30 days after the last day of each month of a rebate period under the agreement (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1) of this section), customary prompt pay discounts extended to wholesalers, and, (for single source drugs and innovator multiple source drugs), the manufacturer's best price (as defined in subsection (c)(2)(B) of this section) for covered outpatient drugs for the rebate period under the agreement,;''.

Pub. L. 109–171, § 6001(b)(1)(A), (c)(2), inserted ''month of a'' after ''last day of each'' and '', customary prompt pay discounts extended to wholesalers,'' after ''(k)(1) of this section)''.

Subsec. (b)(3)(A)(ii). Pub. L. 109–171, § 6003(a)(2), inserted ''(including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)'' after ''drugs''.

Subsec. (b)(3)(A)(iii). Pub. L. 109–171, § 6001(d)(1), inserted '', and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs'' before period at end.

Subsec. (b)(3)(D)(iv), (v). Pub. L. 109–171, § 6001(b)(2), added cls. (iv) and (v).

Subsec. (c)(1)(C)(i). Pub. L. 109–171, § 6003(b)(1)(A), inserted ''(including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)'' after ''or innovator multiple source drug of a manufacturer'' in introductory provisions.

Subsec. (c)(1)(C)(ii)(IV). Pub. L. 109–171, § 6003(b)(1)(B), added subcl. (IV).

Subsec. (c)(1)(D). Pub. L. 109–171, § 6001(d)(2), added subpar. (D).

Subsec. (e)(4). Pub. L. 109–171, § 6001(a)(1), which directed substitution of ''Subject to paragraph (5), the Secretary'' for ''The Secretary'' and insertion of ''(or, effective January 1, 2007, two or more)'' after ''three or more'' in subsec. (e)(4), was executed to the last par. of subsec. (e) to reflect the probable intent of Congress. See 1993 Amendment note below.

Subsec. (e)(5). Pub. L. 109–171, § 6001(a)(2), added par. (5).

Subsec. (f). Pub. L. 109–171, § 6001(e), added subsec. (f).

Subsec. (g)(1)(B)(i)(II). Pub. L. 109–171, § 6001(f)(1), which directed insertion of ''(or its successor publications)'' after ''United States Pharmacopoeia-Drug Information'', was executed by making insertion after ''United States Pharmacopeia-Drug Information'' to reflect the probable intent of Congress.

Subsec. (g)(2)(A)(ii). Pub. L. 109–171, § 6001(f)(2), inserted '', or to require verification of the offer to provide consultation or a refusal of such offer'' before period at end of concluding provisions.

Subsec. (k)(1). Pub. L. 109–171, § 6001(c)(1), designated existing provisions as subpar. (A), inserted heading, substituted ''Subject to subparagraph (B), the term'' for ''The term'', struck out '', after deducting customary prompt pay discounts'' before period at end, and added subpar. (B).

Subsec. (k)(1)(C). Pub. L. 109–171, § 6003(b)(2), as amended by Pub. L. 109–432, added subpar. (C).

Subsec. (k)(7)(A)(i). Pub. L. 109–171, § 6001(a)(4), substituted ''is'' for ''are'' in subcls. (I), (II), and (III).

Pub. L. 109–171, § 6001(a)(3), substituted ''at least 1 other drug product'' for ''are 2 or more drug products'' in introductory provisions.

2005—Subsec. (d)(2)(K). Pub. L. 109–91 added subpar. (K).

2003—Subsec. (a)(1). Pub. L. 108–173, §303(i)(4)(A), inserted ''or under part B of subchapter XVIII'' after ''section 1396b(a) of this title''.

Subsec. (b)(3)(A). Pub. L. 108–173, §303(i)(4)(B), added cl. (iii) and concluding provisions.

Subsec. (b)(3)(B). Pub. L. 108–173, §303(i)(4)(C), inserted ''and manufacturer's average sales price'' after ''average manufacturer price'' in heading and ''and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment'' after ''manufacturer prices'' in text.

Subsec. (b)(3)(D). Pub. L. 108–173, §303(i)(4)(D)(i), inserted ''(other than the wholesale acquisition cost for purposes of carrying out section 1395w–3a of this title)'' after ''subsection (a)(6)(A)(ii)'' in introductory provisions.

Pub. L. 108–173, §105(b), which directed insertion of ''and drug pricing data reported under the first sentence of section 1395w–141(i)(1) of this title'' after ''section 1395w–104(c)(2)(E) of this title'' in last sentence, was executed by making the insertion after ''or 1395w–104(c)(2)(E) of this title'' in concluding provisions to reflect the probable intent of Congress.

Pub. L. 108–173, §101(e)(4), inserted concluding provisions.

Subsec. (b)(3)(D)(i). Pub. L. 108–173, §303(i)(4)(D)(ii), inserted '', to carry out section 1395w–3a of this title (including the determination and implementation of the payment amount), or to carry out section 1395w–3b of this title'' after ''this section''.

Subsec. (c)(1)(C)(i)(I). Pub. L. 108–173, §1002(a), inserted ''(including inpatient prices charged to hospitals described in section 256b(a)(4)(L) of this title)'' before semicolon at end.

Subsec. (c)(1)(C)(i)(V), (VI). Pub. L. 108–173, §103(e)(1), added subcls. (V) and (VI).

Subsec. (c)(1)(C)(iii). Pub. L. 108–173, §1002(b), added cl. (iii).

Subsec. (e)[(4)]. Pub. L. 108–173, §900(e)(1)(K), (L), which directed substitution of ''The Secretary'' for ''HCFA'' in subsecs. (e)(4) and (f)(2), was executed to the last par. of subsec. (e) to reflect the probable intent of Congress. See 1993 Amendment note below.

Subsec. (g)(1)(B)(i)(II). Pub. L. 108–173, §101(e)(9)(A), inserted ''and'' at end.

Subsec. (g)(1)(B)(i)(IV). Pub. L. 108–173, §101(e)(9)(B), struck out subcl. (IV) which read as follows: ''American Medical Association Drug Evaluations; and''.

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title VI, §606(a)], substituted ''shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before'' for ''shall not be effective until''.

Subsec. (g)(2)(A)(ii)(II)(cc). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(1)], substituted ''individual's'' for ''individuals''.

Subsec. (i)(1). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(2)], substituted ''the operation of this section'' for ''the the operation of this section''.

Subsec. (k)(7)(A)(iv). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(3)(A)], substituted ''distributors'' for ''distributers''.

Subsec. (k)(7)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(3)(B)], substituted ''pharmaceutically'' for ''pharmaceuutically''.

1997—Subsec. (g)(1)(B)(i)(III), (IV). Pub. L. 105–33, §4756, added subcl. (III) and redesignated former subcl. (III) as (IV).

Subsec. (j)(1). Pub. L. 105–33, §4701(b)(2)(A)(x), substituted ''health maintenance organizations, including medicaid managed care organizations'' for ''* * * Health Maintenance Organizations, including those organizations''.

1993—Subsec. (b)(1)(A). Pub. L. 103–66, §13602(a)(2)(A)(i)(II), which directed amendment of subpar. (A) by substituting ''dispensed after December 31, 1990, for which payment was made under the State plan for such period'' for ''dispensed under the plan during the quarter (or other period as the Secretary may specify)'', was executed by making the substitution for ''dispensed under the plan during the quarter (or such other period as the Secretary may specify)'' to reflect the probable intent of Congress.

Pub. L. 103–66, §13602(a)(2)(A)(i)(I), substituted ''for a rebate period'' for ''each calendar quarter (or periodically in accordance with a schedule specified by the Secretary)''.

Subsec. (b)(2)(A). Pub. L. 103–66, §13602(a)(2)(A)(ii), substituted ''each rebate period'' for ''each calendar quarter'' and ''units of each dosage form and strength and package size'' for ''dosage units'', inserted ''after December 31, 1990, for which payment was made'' after ''dispensed'', and substituted ''during the period'' for ''during the quarter''.

Subsec. (b)(3)(A)(i). Pub. L. 103–66, §13602(a)(2)(A)(iii), substituted ''rebate period under the agreement'' for ''quarter'' in two places.

Subsec. (c). Pub. L. 103–66, §13602(a)(1), added subsec. (c) and struck out former subsec. (c) which related to determination of amount of rebate for certain drugs.

Pub. L. 103–18 substituted ''such drug, except that for the calendar quarter beginning after September 30, 1992, and before January 1, 1993, the amount of the rebate may not exceed 50 percent of such average manufacturer price;'' for ''such drug;'' in par. (1)(B)(ii)(II).

Subsecs. (d) to (f). Pub. L. 103–66, §13602(a)(1), added subsecs. (d) and (e), struck out former subsecs. (d) consisting of pars. (1) to (8) relating to limitations on coverage of drugs, (e) relating to denial of Federal financial participation in certain cases, and (f)(1) relating to reductions in pharmacy reimbursement limits, and struck out par. designation for former par. (2) of subsec. (f) without supplying a new designation. The text of former subsec. (f)(2) is now the last par. of subsec. (e).

Subsec. (k)(1). Pub. L. 103–66, §13602(a)(2)(B)(i), substituted ''rebate period'' for ''calendar quarter'' and inserted before period at end '', after deducting customary prompt pay discounts''.

Subsec. (k)(3). Pub. L. 103–66, §13602(a)(2)(B)(ii)(III), in concluding provisions, substituted ''for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used'' for ''which is used'' and inserted at end ''Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.''

Subsec. (k)(3)(E). Pub. L. 103–66, §13602(a)(2)(B)(ii)(I), struck out ''* * * *emergency room visits'' after ''services''.

Subsec. (k)(3)(F). Pub. L. 103–66, §13602(a)(2)(B)(ii)(II), which directed amendment of subpar. (F) by substituting ''services and services provided by an intermediate care facility for the mentally retarded'' for ''services'', was executed by making the substitution for ''sevices'' to reflect the probable intent of Congress because the word ''services'' did not appear.

Subsec. (k)(6). Pub. L. 103–66, §13602(a)(2)(B)(iii), substituted ''or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i).'' for '', which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.''

Subsec. (k)(7)(A)(i). Pub. L. 103–66, §13602(a)(2)(B)(iv), substituted ''rebate period'' for ''calendar quarter'' in introductory provisions.

Subsec. (k)(8), (9). Pub. L. 103–66, §13602(a)(2)(B)(v), added par. (8) and redesignated former par. (8) as (9).

1992—Subsec. (a)(1). Pub. L. 102–585, §601(b)(1), substituted ''manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first

month that begins after November 4, 1992) and paragraph (6)'' for ''manufacturer)''.

Subsec. (a)(5), (6). Pub. L. 102–585, §601(b)(2), added pars. (5) and (6).

Subsec. (b)(3)(D). Pub. L. 102–585, §601(b)(3), substituted ''this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii)'' for ''this paragraph'', ''Secretary or the Secretary of Veterans Affairs'' for ''Secretary'', and ''except—'' and cls. (i) to (iii) for ''except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided.''

Subsec. (b)(4)(B)(ii). Pub. L. 102–585, §601(b)(4)(i), (ii), substituted ''the calendar quarter beginning at least 60 days'' for ''such period'' and ''the manufacturer provides notice to the Secretary.'' for ''of the notice as the Secretary may provide (but not beyond the term of the agreement).''

Subsec. (b)(4)(B)(iv), (v). Pub. L. 102–585, §601(b)(4)(iii), added cls. (iv) and (v).

Subsec. (c)(1)(B)(i). Pub. L. 102–585, §601(c)(1), which directed the substitution of ''October 1, 1992,'' for ''January 1, 1993,'', was executed by making the substitution in introductory provisions and in subcl. (II), to reflect the probable intent of Congress.

Subsec. (c)(1)(B)(ii) to (v). Pub. L. 102–585, §601(c)(2), (3), added cls. (ii) to (v) and struck out former cl. (ii) which read as follows: ''for quarters (or other periods) beginning after December 31, 1992, the greater of—

''(I) the difference between the average manufacturer price for a drug and 85 percent of such price, or

''(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug.''

Subsec. (c)(1)(C). Pub. L. 102–585, §601(a), substituted ''(excluding any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of this section, any prices charged under the Federal Supply Schedule of the General Services Administration, or any prices used under a State pharmaceutical assistance program, and excluding'' for ''(excluding''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment made by Pub. L. 116–159 effective as if included in the enactment of section 1006(b) of the SUPPORT for Patients and Communities Act (Public Law 115–271; 132 Stat. 3914), see section 2601(c) of Pub. L. 116–159, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–59, div. B, title VI, §1603(c), Sept. 27, 2019, 133 Stat. 1108, provided that: ''The amendments made by this section [amending this section] shall take effect on the first day of the first fiscal quarter that begins after the date of enactment of this Act [Sept. 27, 2019].''

Amendment by Pub. L. 116–16 effective on Apr. 18, 2019, and applicable to covered outpatient drugs supplied by manufacturers under agreements under this section on or after that date, see section 6(e) of Pub. L. 116–16, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1004(b)(2), Oct. 24, 2018, 132 Stat. 3912, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect with respect to retrospective drug use reviews conducted on or after October 1, 2020.''

Pub. L. 115–123, div. E, title XII, §53104(b), Feb. 9, 2018, 132 Stat. 302, provided that: ''The amendments made [by] subsection (a) [amending this section] shall apply with respect to rebate periods beginning on or after October 1, 2018.''

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–198, title VII, §705(b), July 22, 2016, 130 Stat. 753, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to drugs that are paid for by a State in calendar quarters beginning on or after the date of the enactment of this Act [July 22, 2016].''

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VI, §602(b), Nov. 2, 2015, 129 Stat. 597, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to rebate periods beginning after the date that is one year after the date of the enactment of this Act [Nov. 2, 2015].''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–226, title II, §202, Aug. 10, 2010, 124 Stat. 2394, provided that the amendment made by Pub. L. 111–226 is effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–152, title I, §1206(b), Mar. 30, 2010, 124 Stat. 1057, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Patient Protection and Affordable Care Act [Pub. L. 111–148].''

Pub. L. 111–148, title II, §2501(d)(2), Mar. 23, 2010, 124 Stat. 309, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to drugs that are paid for by a State after December 31, 2009.''

Pub. L. 111–148, title II, §2502(b), Mar. 23, 2010, 124 Stat. 310, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after January 1, 2014.''

Pub. L. 111–148, title II, §2503(d), Mar. 23, 2010, 124 Stat. 312, provided that: ''The amendments made by this section [amending this section] shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act [Mar. 23, 2010], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.''

Amendment by section 3301(d)(2) of Pub. L. 111–148 applicable to drugs dispensed on or after July 1, 2010, see section 3301(d)(3) of Pub. L. 111–148, set out as a note under section 1320a–7b of this title.

Amendment by section 4107(b) of Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–8, div. F, title II, §221(b), Mar. 11, 2009, 123 Stat. 783, provided that: ''The amendments made by this subsection [probably means this section, amending this section] shall take effect as if included in the amendment made by section 6001(d)(2) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].''

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title VI, §6001(f)(3), Feb. 8, 2006, 120 Stat. 58, provided that: ''The amendments made by this subsection [amending this section and section 1395x of this title] shall take effect on the date of the enactment of this Act [Feb. 8, 2006].''

Pub. L. 109–171, title VI, §6001(g), Feb. 8, 2006, 120 Stat. 58, provided that: ''Except as otherwise provided, the amendments made by this section [amending this section and section 1395x of this title] shall take effect on January 1, 2007, without regard to whether or not final

regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 109–171, title VI, § 6003(c), Feb. 8, 2006, 120 Stat. 61, provided that: ''The amendments made by this section [amending this section] take effect on January 1, 2007.''

Pub. L. 109–171, title VI, § 6004(b), Feb. 8, 2006, 120 Stat. 61, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to drugs purchased on or after the date of the enactment of this Act [Feb. 8, 2006].''

EFFECTIVE DATE OF 2005 AMENDMENT

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

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, § 103(e)(2), Dec. 8, 2003, 117 Stat. 2160, provided that: ''Section 1927(c)(1)(C)(i)(VI) of the Social Security Act [42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)], as added by paragraph (1), shall apply to prices charged for drugs dispensed on or after January 1, 2006.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 606(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, provided that: ''The amendment made by subsection (a) [amending this section] applies to agreements entered into on or after the date of enactment of this Act [Nov. 29, 1999].''

Amendment by section 1000(a)(6) [title VI, § 608(u)] 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 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13602(d), Aug. 10, 1993, 107 Stat. 619, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 1396a and 1396b of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].

''(2) The amendment made by subsection (a)(1) [amending this section] (insofar as such subsection amends section 1927(d) of the Social Security Act [42 U.S.C. 1396r–8(d)]) and the amendment made by subsection (c) [amending section 1396a of this title] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not regulations to carry out such amendments have been promulgated by such date.''

Pub. L. 103–18, § 2(b), Apr. 12, 1993, 107 Stat. 54, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 601(c) of the Veterans Health Care Act of 1992 [Pub. L. 102–585].''

EFFECTIVE DATE OF 1992 AMENDMENT

Pub. L. 102–585, title VI, § 601(e), Nov. 4, 1992, 106 Stat. 4966, provided that: ''The amendments made by this section [amending this section] shall apply with respect to payments to State plans under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters (or periods) beginning on or after January 1, 1993 (without regard to whether or not regulations to carry out such amendments have been promulgated by such date).''

REGULATIONS

Pub. L. 109–171, title VI, § 6001(c)(3), Feb. 8, 2006, 120 Stat. 55, provided that:

''(A) INSPECTOR GENERAL RECOMMENDATIONS.—Not later than June 1, 2006, the Inspector General of the Department of Health and Human Services shall—

''(i) review the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act [42 U.S.C. 1396r–8], as amended by this section; and

''(ii) shall submit to the Secretary of Health and Human Services and Congress such recommendations for changes in such requirements or manner as the Inspector General determines to be appropriate.

''(B) DEADLINE FOR PROMULGATION.—Not later than July 1, 2007, the Secretary of Health and Human Services shall promulgate a regulation that clarifies the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, taking into consideration the recommendations submitted to the Secretary in accordance with subparagraph (A)(ii).''

INCLUSION IN THE MEDICAID DRUG REBATE PROGRAM OF COVERED OUTPATIENT DRUGS USED FOR COVID–19 TREATMENT

Pub. L. 117–2, title IX, § 9811(a)(4)(A), Mar. 11, 2021, 135 Stat. 210, provided that:

''(A) IN GENERAL.—The requirements of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) shall apply to any drug or biological product to which subparagraph (F) of section 1905(a)(4) of such Act [42 U.S.C. 1396d(a)(4)], as added by paragraph (1), applies or to which the subclause (XVIII) in the matter following subparagraph (G) of section 1902(a)(10) of such Act [42 U.S.C. 1396a(a)(10)], as added by paragraph (2), applies that is—

''(i) furnished as medical assistance in accordance with section 1902(a)(10)(A) of such Act and such subparagraph (F) [probably means 42 U.S.C. 1396d(a)(4)(F)] or subclause (XVIII) [probably means subcl. (XVIII) in 42 U.S.C. 1396a(a)(10) concluding provisions] and section 1902(a)(10)(A) of such Act, as applicable, for the treatment, or prevention, of COVID–19, as described in such subparagraph or subclause, respectively; and

''(ii) a covered outpatient drug (as defined in section 1927(k) of such Act, except that, in applying paragraph (2)(A) of such section [probably means 42 U.S.C. 1396r–8(k)(2)(A)] to a drug to which such subparagraph (F) [probably means 42 U.S.C. 1396d(a)(4)(F)] or such subclause (XVIII) [probably means subcl. (XVIII) in 42 U.S.C. 1396a(a)(10) concluding provisions] applies, such drug shall be deemed a prescribed drug for purposes of section 1905(a)(12) of such Act).''

PHARMACY REIMBURSEMENT UNDER MEDICAID

Pub. L. 110–275, title II, § 203, July 15, 2008, 122 Stat. 2592, provided that:

''(a) DELAY IN APPLICATION OF NEW PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS UNDER MEDICAID.—Notwithstanding paragraphs (4) and (5) of subsection (e) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) or part 447 of title 42, Code of Federal Regulations, as published on July 17, 2007 (72 Federal Register 39142)—

''(1) the specific upper limit under section 447.332 of title 42, Code of Federal Regulations (as in effect on December 31, 2006) applicable to payments made by a State for multiple source drugs under a State Medicaid plan shall continue to apply through September 30, 2009, for purposes of the availability of Federal financial participation for such payments; and

''(2) the Secretary of Health and Human Services shall not, prior to October 1, 2009, finalize, implement, enforce, or otherwise take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose the

specific upper limit established under section 447.514(b) of title 42, Code of Federal Regulations as published on July 17, 2007 (72 Federal Register 39142).

''(b) TEMPORARY SUSPENSION OF UPDATED PUBLICLY AVAILABLE AMP DATA.—Notwithstanding clause (v) of section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)), the Secretary of Health and Human Services shall not, prior to October 1, 2009, make publicly available any AMP disclosed to the Secretary.

''(c) DEFINITIONS.—In this subsection:

''(1) The term 'multiple source drug' has the meaning given that term in section 1927(k)(7)(A)(i) of the Social Security Act (42 U.S.C. 1396r–8(k)(7)(A)(i)).

''(2) The term 'AMP' has the meaning given 'average manufacturer price' in section 1927(k)(1) of the Social Security Act (42 U.S.C. 1396r–8(k)(1)) and 'AMP' in section 447.504(a) of title 42, Code of Federal Regulations as published on July 17, 2007 (72 Federal Register 39142).''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under subchapter XVIII of this chapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

REPORTS ON BEST PRICE CHANGES AND PAYMENT OF REBATES

Pub. L. 102–585, title VI, §601(d), Nov. 4, 1992, 106 Stat. 4965, provided that not later than 90 days after the expiration of each calendar quarter beginning on or after Oct. 1, 1992, and ending on or before Dec. 31, 1995, Secretary of Health and Human Services was to submit to Congress a report containing information as to percentage of single source drugs whose best price either increased, decreased, or stayed the same in comparison to best price during previous calendar quarter, median and mean percentage increase or decrease of such price, and, with respect to drugs for which manufacturers were required to pay rebates under subsec. (c) of this section, Secretary's best estimate, on State-by-State and national aggregate basis, of total amount of rebates paid under subsec. (c) of this section and percentages of such total amounts attributable to rebates paid under pars. (1) to (3) of subsec. (c) of this section, limited consideration to drugs which are considered significant expenditures under medicaid program, and contained requirements for initial report.

DEMONSTRATION PROJECTS TO EVALUATE EFFICIENCY AND COST-EFFECTIVENESS OF PROSPECTIVE DRUG UTILIZATION REVIEW

Pub. L. 101–508, title IV, §4401(c), Nov. 5, 1990, 104 Stat. 1388–159, directed Secretary of Health and Human Services to establish statewide demonstration projects to evaluate efficiency and cost-effectiveness of prospective drug utilization review and to evaluate impact on quality of care and cost-effectiveness of paying pharmacists under this subchapter whether or not drugs were dispensed for drug use review services, with two reports to be submitted to Congress, the first not later than Jan. 1, 1994, and the second not later than Jan. 1, 1995.

STUDY OF DRUG PURCHASING AND BILLING PRACTICES IN HEALTH CARE INDUSTRY; REPORT

Pub. L. 101–508, title IV, §4401(d), Nov. 5, 1990, 104 Stat. 1388–160, as amended by Pub. L. 104–316, title I, §122(i), Oct. 19, 1996, 110 Stat. 3837, provided for various studies and reports as follows: (1) directed Comptroller General to conduct study of drug purchasing and billing activities of various health care systems, and to submit report to Secretary of Health and Human Services and to Congress by not later than May 1, 1991; (2) directed Comptroller General to submit to Secretary and Congress report on changes in prices charged by manufacturers for prescription drugs to Department of Veterans Affairs, other Federal programs, hospital pharmacies, and other purchasing groups and managed care plans; (3) directed Secretary, acting in consultation with Comptroller General, to study prior approval procedures utilized by State medical assistance programs conducted under this subchapter, and to submit report to Congress by not later than Dec. 31, 1991; (4) directed Secretary to conduct study on adequacy of current reimbursement rates to pharmacists under each State medical assistance program conducted under this subchapter, and to submit report to Congress by not later than Dec. 31, 1991; and (5) directed Secretary to undertake study of relationship between State medical assistance plans and Federal and State acquisition and reimbursement policies for vaccines and accessibility of vaccinations and immunization to children, and to report to Congress not later than one year after Nov. 5, 1990.

§ 1396s. Program for distribution of pediatric vaccines

(a) Establishment of program

(1) In general

In order to meet the requirement of section 1396a(a)(62) of this title, each State shall establish a pediatric vaccine distribution program (which may be administered by the State department of health), consistent with the requirements of this section, under which—

(A) each vaccine-eligible child (as defined in subsection (b)), in receiving an immunization with a qualified pediatric vaccine (as defined in subsection (h)(8)) from a program-registered provider (as defined in subsection (c)) on or after October 1, 1994, is entitled to receive the immunization without charge for the cost of such vaccine; and

(B)(i) each program-registered provider who administers such a pediatric vaccine to a vaccine-eligible child on or after such date is entitled to receive such vaccine under the program without charge either for the vaccine or its delivery to the provider, and (ii) no vaccine is distributed under the program to a provider unless the provider is a program-registered provider.

(2) Delivery of sufficient quantities of pediatric vaccines to immunize federally vaccine-eligible children

(A) In general

The Secretary shall provide under subsection (d) for the purchase and delivery on behalf of each State meeting the requirement of section 1396a(a)(62) of this title (or, with respect to vaccines administered by an Indian tribe or tribal organization to Indian children, directly to the tribe or organization), without charge to the State, of such

quantities of qualified pediatric vaccines as may be necessary for the administration of such vaccines to all federally vaccine-eligible children in the State on or after October 1, 1994. This paragraph constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the purchase and delivery to States of the vaccines (or payment under subparagraph (C)) in accordance with this paragraph.

(B) Special rules where vaccine is unavailable

To the extent that a sufficient quantity of a vaccine is not available for purchase or delivery under subsection (d), the Secretary shall provide for the purchase and delivery of the available vaccine in accordance with priorities established by the Secretary, with priority given to federally vaccine-eligible children unless the Secretary finds there are other public health considerations.

(C) Special rules where State is a manufacturer

(i) Payments in lieu of vaccines

In the case of a State that manufactures a pediatric vaccine the Secretary, instead of providing the vaccine on behalf of a State under subparagraph (A), shall provide to the State an amount equal to the value of the quantity of such vaccine that otherwise would have been delivered on behalf of the State under such subparagraph, but only if the State agrees that such payments will only be used for purposes relating to pediatric immunizations.

(ii) Determination of value

In determining the amount to pay a State under clause (i) with respect to a pediatric vaccine, the value of the quantity of vaccine shall be determined on the basis of the price in effect for the qualified pediatric vaccine under contracts under subsection (d). If more than 1 such contract is in effect, the Secretary shall determine such value on the basis of the average of the prices under the contracts, after weighting each such price in relation to the quantity of vaccine under the contract involved.

(b) Vaccine-eligible children

For purposes of this section:

(1) In general

The term ''vaccine-eligible child'' means a child who is a federally vaccine-eligible child (as defined in paragraph (2)) or a State vaccine-eligible child (as defined in paragraph (3)).

(2) Federally vaccine-eligible child

(A) In general

The term ''federally vaccine-eligible child'' means any of the following children:

(i) A medicaid-eligible child.

(ii) A child who is not insured.

(iii) A child who (I) is administered a qualified pediatric vaccine by a federally-qualified health center (as defined in section 1396d(*l*)(2)(B) of this title) or a rural health clinic (as defined in section 1396d(*l*)(1) of this title), and (II) is not insured with respect to the vaccine.

(iv) A child who is an Indian (as defined in subsection (h)(3)).

(B) Definitions

In subparagraph (A):

(i) The term ''medicaid-eligible'' means, with respect to a child, a child who is entitled to medical assistance under a state[1] plan approved under this subchapter.

(ii) The term ''insured'' means, with respect to a child—

(I) for purposes of subparagraph (A)(ii), that the child is enrolled under, and entitled to benefits under, a health insurance policy or plan, including a group health plan, a prepaid health plan, or an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.]; and

(II) for purposes of subparagraph (A)(iii)(II) with respect to a pediatric vaccine, that the child is entitled to benefits under such a health insurance policy or plan, but such benefits are not available with respect to the cost of the pediatric vaccine.

(3) State vaccine-eligible child

The term ''State vaccine-eligible child'' means, with respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B).

(c) Program-registered providers

(1) Defined

In this section, except as otherwise provided, the term ''program-registered provider'' means, with respect to a State, any health care provider that—

(A) is licensed or otherwise authorized for administration of pediatric vaccines under the law of the State in which the administration occurs (subject to section 254f(e) of this title), without regard to whether or not the provider participates in the plan under this subchapter;

(B) submits to the State an executed provider agreement described in paragraph (2); and

(C) has not been found, by the Secretary or the State, to have violated such agreement or other applicable requirements established by the Secretary or the State consistent with this section.

(2) Provider agreement

A provider agreement for a provider under this paragraph is an agreement (in such form and manner as the Secretary may require) that the provider agrees as follows:

(A)(i) Before administering a qualified pediatric vaccine to a child, the provider will ask a parent of the child such questions as are necessary to determine whether the

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

child is a vaccine-eligible child, but the provider need not independently verify the answers to such questions.

(ii) The provider will, for a period of time specified by the Secretary, maintain records of responses made to the questions.

(iii) The provider will, upon request, make such records available to the State and to the Secretary, subject to section 1396a(a)(7) of this title.

(B)(i) Subject to clause (ii), the provider will comply with the schedule, regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines, that is established and periodically reviewed and, as appropriate, revised by the advisory committee referred to in subsection (e), except in such cases as, in the provider's medical judgment subject to accepted medical practice, such compliance is medically inappropriate.

(ii) The provider will provide pediatric vaccines in compliance with applicable State law, including any such law relating to any religious or other exemption.

(C)(i) In administering a qualified pediatric vaccine to a vaccine-eligible child, the provider will not impose a charge for the cost of the vaccine. A program-registered provider is not required under this section to administer such a vaccine to each child for whom an immunization with the vaccine is sought from the provider.

(ii) The provider may impose a fee for the administration of a qualified pediatric vaccine so long as the fee in the case of a federally vaccine-eligible child does not exceed the costs of such administration (as determined by the Secretary based on actual regional costs for such administration).

(iii) The provider will not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child's parent to pay an administration fee.

(3) Encouraging involvement of providers

Each program under this section shall provide, in accordance with criteria established by the Secretary—

(A) for encouraging the following to become program-registered providers: private health care providers, the Indian Health Service, health care providers that receive funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.], and health programs or facilities operated by Indian tribes or tribal organizations; and

(B) for identifying, with respect to any population of vaccine-eligible children a substantial portion of whose parents have a limited ability to speak the English language, those program-registered providers who are able to communicate with the population involved in the language and cultural context that is most appropriate.

(4) State requirements

Except as the Secretary may permit in order to prevent fraud and abuse and for related purposes, a State may not impose additional qualifications or conditions, in addition to the requirements of paragraph (1), in order that a provider qualify as a program-registered provider under this section. This subsection does not limit the exercise of State authority under section 1396n(b) of this title.

(d) Negotiation of contracts with manufacturers

(1) In general

For the purpose of meeting obligations under this section, the Secretary shall negotiate and enter into contracts with manufacturers of pediatric vaccines consistent with the requirements of this subsection and, to the maximum extent practicable, consolidate such contracting with any other contracting activities conducted by the Secretary to purchase vaccines. The Secretary may enter into such contracts under which the Federal Government is obligated to make outlays, the budget authority for which is not provided for in advance in appropriations Acts, for the purchase and delivery of pediatric vaccines under subsection (a)(2)(A).

(2) Authority to decline contracts

The Secretary may decline to enter into such contracts and may modify or extend such contracts.

(3) Contract price

(A) In general

The Secretary, in negotiating the prices at which pediatric vaccines will be purchased and delivered from a manufacturer under this subsection, shall take into account quantities of vaccines to be purchased by States under the option under paragraph (4)(B).

(B) Negotiation of discounted price for current vaccines

With respect to contracts entered into under this subsection for a pediatric vaccine for which the Centers for Disease Control and Prevention has a contract in effect under section 247b(j)(1) of this title as of May 1, 1993, no price for the purchase of such vaccine for vaccine-eligible children shall be agreed to by the Secretary under this subsection if the price per dose of such vaccine (including delivery costs and any applicable excise tax established under section 4131 of the Internal Revenue Code of 1986) exceeds the price per dose for the vaccine in effect under such a contract as of such date increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from May 1993 to the month before the month in which such contract is entered into.

(C) Negotiation of discounted price for new vaccines

With respect to contracts entered into for a pediatric vaccine not described in subparagraph (B), the price for the purchase of such vaccine shall be a discounted price negotiated by the Secretary that may be established without regard to such subparagraph.

(4) Quantities and terms of delivery

Under such contracts—

(A) the Secretary shall provide, consistent with paragraph (6), for the purchase and delivery on behalf of States (and tribes and tribal organizations) of quantities of pediatric vaccines for federally vaccine-eligible children; and

(B) each State, at the option of the State, shall be permitted to obtain additional quantities of pediatric vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through purchasing the vaccines from the manufacturers at the applicable price negotiated by the Secretary consistent with paragraph (3), if (i) the State agrees that the vaccines will be used to provide immunizations only for children who are not federally vaccine-eligible children and (ii) the State provides to the Secretary such information (at a time and manner specified by the Secretary, including in advance of negotiations under paragraph (1)) as the Secretary determines to be necessary, to provide for quantities of pediatric vaccines for the State to purchase pursuant to this subsection and to determine annually the percentage of the vaccine market that is purchased pursuant to this section and this subparagraph.

The Secretary shall enter into the initial negotiations under the preceding sentence not later than 180 days after August 10, 1993.

(5) Charges for shipping and handling

The Secretary may enter into a contract referred to in paragraph (1) only if the manufacturer involved agrees to submit to the Secretary such reports as the Secretary determines to be appropriate to assure compliance with the contract and if, with respect to a State program under this section that does not provide for the direct delivery of qualified pediatric vaccines, the manufacturer involved agrees that the manufacturer will provide for the delivery of the vaccines on behalf of the State in accordance with such program and will not impose any charges for the costs of such delivery (except to the extent such costs are provided for in the price established under paragraph (3)).

(6) Assuring adequate supply of vaccines

The Secretary, in negotiations under paragraph (1), shall negotiate for quantities of pediatric vaccines such that an adequate supply of such vaccines will be maintained to meet unanticipated needs for the vaccines. For purposes of the preceding sentence, the Secretary shall negotiate for a 6-month supply of vaccines in addition to the quantity that the Secretary otherwise would provide for in such negotiations. In carrying out this paragraph, the Secretary shall consider the potential for outbreaks of the diseases with respect to which the vaccines have been developed.

(7) Multiple suppliers

In the case of the pediatric vaccine involved, the Secretary shall, as appropriate, enter into a contract referred to in paragraph (1) with each manufacturer of the vaccine that meets the terms and conditions of the Secretary for an award of such a contract (including terms and conditions regarding safety and quality). With respect to multiple contracts entered into pursuant to this paragraph, the Secretary may have in effect different prices under each of such contracts and, with respect to a purchase by States pursuant to paragraph (4)(B), the Secretary shall determine which of such contracts will be applicable to the purchase.

(e) Use of pediatric vaccines list

The Secretary shall use, for the purpose of the purchase, delivery, and administration of pediatric vaccines under this section, the list established (and periodically reviewed and as appropriate revised) 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).

(f) Requirement of State maintenance of immunization laws

In the case of a State that had in effect as of May 1, 1993, a law that requires some or all health insurance policies or plans to provide some coverage with respect to a pediatric vaccine, a State program under this section does not comply with the requirements of this section unless the State certifies to the Secretary that the State has not modified or repealed such law in a manner that reduces the amount of coverage so required.

(g) Termination

This section, and the requirement of section 1396a(a)(62) of this title, shall cease to be in effect beginning on such date as may be prescribed in Federal law providing for immunization services for all children as part of a broad-based reform of the national health care system.

(h) Definitions

For purposes of this section:

(1) The term ''child'' means an individual 18 years of age or younger.

(2) The term ''immunization'' means an immunization against a vaccine-preventable disease.

(3) The terms ''Indian'', ''Indian tribe'' and ''tribal organization'' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603].

(4) The term ''manufacturer'' means any corporation, organization, or institution, whether public or private (including Federal, State, and local departments, agencies, and instrumentalities), which manufactures, imports, processes, or distributes under its label any pediatric vaccine. The term ''manufacture'' means to manufacture, import, process, or distribute a vaccine.

(5) The term ''parent'' includes, with respect to a child, an individual who qualifies as a legal guardian under State law.

(6) The term ''pediatric vaccine'' means a vaccine included on the list under subsection (e).

(7) The term ''program-registered provider'' has the meaning given such term in subsection (c).

(8) The term ''qualified pediatric vaccine'' means a pediatric vaccine with respect to

which a contract is in effect under subsection (d).

(9) The terms ''vaccine-eligible child'', ''federally vaccine-eligible child'', and ''State vaccine-eligible child'' have the meaning given such terms in subsection (b).

(Aug. 14, 1935, ch. 531, title XIX, § 1928, as added Pub. L. 103–66, title XIII, § 13631(b)(2), Aug. 10, 1993, 107 Stat. 637.)

Editorial Notes

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsec. (b)(2)(B)(ii)(I), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829, which is classified principally to chapter 18 (§ 1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (c)(3)(A), 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, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

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

PRIOR PROVISIONS

A prior section 1396s, act Aug. 14, 1935, ch. 531, title XIX, § 1928, formerly § 1920, as added Apr. 7, 1986, Pub. L. 99–272, title IX, § 9526, 100 Stat. 218, and renumbered and amended, which related to references to laws directly affecting medicaid program, was renumbered section 1931 of act Aug. 14, 1935, by Pub. L. 103–66, title XIII, § 13631(b)(1), Aug. 10, 1993, 107 Stat. 637, and transferred to section 1396v of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable to payments under State plans approved under this subchapter for calendar quarters beginning on or after Oct. 1, 1994, see section 13631(i) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 1396a of this title.

§ 1396t. Home and community care for functionally disabled elderly individuals

(a) "Home and community care" defined

In this subchapter, the term ''home and community care'' means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

(1) Homemaker/home health aide services.

(2) Chore services.

(3) Personal care services.

(4) Nursing care services provided by, or under the supervision of, a registered nurse.

(5) Respite care.

(6) Training for family members in managing the individual.

(7) Adult day care.

(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

(b) "Functionally disabled elderly individual" defined

(1) In general

In this subchapter, the term ''functionally disabled elderly individual'' means an individual who—

(A) is 65 years of age or older,

(B) is determined to be a functionally disabled individual under subsection (c), and

(C) subject to section 1396a(f) of this title (as applied consistent with section 1396a(r)(2) of this title), is receiving supplemental security income benefits under subchapter XVI (or under a State plan approved under subchapter XVI) or, at the option of the State, is described in section 1396a(a)(10)(C) of this title.

(2) Treatment of certain individuals previously covered under a waiver

(A) In the case of a State which—

(i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under section 1396n(c) or 1396n(d) of this title with respect to individuals 65 years of age or older, and

(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and community care under the plan shall, notwithstanding any other provision of this subchapter, be deemed a functionally disabled elderly individual for so long as the individual would have remained eligible for medical assistance under such waiver.

(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under section 1315 of this title that provides under the State plan under this subchapter for personal care services for functionally disabled individuals, the term ''functionally disabled elderly individual'' may include, at the option of the State, an individual who—

(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under subchapter XVI);

(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title.

(3) Use of projected income

In applying section 1396b(f)(1) of this title in determining the eligibility of an individual (described in section 1396a(a)(10)(C) of this

title) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

(c) Determinations of functional disability

(1) In general

In this section, an individual is ''functionally disabled'' if the individual—

(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(2) Assessments of functional disability

(A) Requests for assessments

If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

(i) is used to determine whether or not the individual is functionally disabled,

(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

(B) Specification of assessment instrument

The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be—

(i) one of the instruments designated under subparagraph (C)(ii); or

(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

(C) Specification of assessment data set and instruments

The Secretary shall—

(i) not later than July 1, 1991—

(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

(II) establish guidelines for use of the data set; and

(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

(D) Periodic review

Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

(E) Conduct of assessment by interdisciplinary teams

An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

(i) with public organizations; or

(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

(F) Contents of assessment

The interdisciplinary team must—

(i) identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual's ICCP under subsection (d)(1).

(G) Appeal procedures

Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

(d) Individual community care plan (ICCP)

(1) "Individual community care plan" defined

In this section, the terms ''individual community care plan'' and ''ICCP'' mean, with respect to a functionally disabled elderly individual, a written plan which—

(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive func-

tional assessment of such individual conducted under subsection (c)(2);

(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual's preferences for the types and providers of services; and

(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

(2) "Qualified community care case manager" defined

In this section, the term ''qualified community care case manager'' means a nonprofit or public agency or organization which—

(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

(D) has procedures for assuring the quality of case management services that includes a peer review process;

(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

(F) meets such other standards, established by the Secretary, as to assure that—

(i) such a manager is competent to perform case management functions;

(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

(3) Appeals process

Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

(e) Ceiling on payment amounts and maintenance of effort

(1) Ceiling on payment amounts

Payments may not be made under section 1396b(a) of this title to a State for home and community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 50 percent of the product of—

(A) the average number of individuals in the quarter receiving such care under this section;

(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under subchapter XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

(C) the number of days in such quarter.

(2) Maintenance of effort

(A) Annual reports

As a condition for the receipt of payment under section 1396b(a) of this title with respect to medical assistance provided by a State for home and community care (other than a waiver under section 1396n(c) of this title and other than home health care services described in section 1396d(a)(7) of this title and personal care services specified under regulations under section 1396d(a)(23) of this title), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

(B) Reduction in payment if failure to maintain effort

If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under section 1396b(a) of this title in an amount equal to the difference between the amounts so reported.

(f) Minimum requirements for home and community care

(1) Requirements

Home and Community[1] care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (k). Such requirements shall include—

(A) the requirement that individuals providing care are competent to provide such care; and

[1] So in original. Probably should not be capitalized.

(B) the rights specified in paragraph (2).

(2) Specified rights

The rights specified in this paragraph are as follows:

(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

(C) The right to confidentiality of personal and clinical records.

(D) The right to privacy and to have one's property treated with respect.

(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(F) The right to education or training for oneself and for members of one's family or household on the management of care.

(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's ICCP.

(H) The right to be fully informed orally and in writing of the individual's rights.

(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

(J) Any other rights established by the Secretary.

(g) Minimum requirements for small community care settings

(1) "Small community care setting" defined

In this section, the term ''small community care setting'' means—

(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

(2) Minimum requirements

A small community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1396r(c) of this title, to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting;

(D) meet any applicable State or local requirements regarding certification or licensure;

(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

(h) Minimum requirements for large community care settings

(1) "Large community care setting" defined

In this section, the term ''large community care setting'' means—

(A) a nonresidential setting in which more than 8 individuals are served; or

(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

(2) Minimum requirements

A large community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1396r(c) of this title, to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting; and

(D) meet the requirements of paragraphs (2) and (3) of section 1396r(d) of this title (relating to administration and other matters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of section 1396r(d)(2) of this title (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

(3) Disclosure of ownership and control interests and exclusion of repeated violators

A community care setting—

(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1320a–3(a)(3) of this title) in the setting; and

(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this subchapter or who has had such an ownership or control interest in one or more community care settings which have been found

repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

(i) Survey and certification process

(1) Certifications

(A) Responsibilities of the State

Under each State plan under this subchapter, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the applicable requirements of subsections (f), (g) and (h). The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(B) Responsibilities of the Secretary

The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h).

(C) Frequency of certifications

Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(2) Reviews of providers

(A) In general

The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's performance in providing the care required under ICCP's in accordance with the requirements of subsection (f).

(B) Special reviews of compliance

Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

(3) Surveys of community care settings

(A) In general

The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) Survey protocol

Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (k).

(C) Prohibition of conflict of interest in survey team membership

A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) or who has a personal or familial financial interest in the setting being surveyed.

(D) Validation surveys of community care settings

The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

(E) Special surveys of compliance

Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h), the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

(4) Investigation of complaints and monitoring of providers and settings

Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h).

(5) Investigation of allegations of individual neglect and abuse and misappropriation of individual property

The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review,

and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

(6) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,

(ii) copies of cost reports (if any) of such providers and settings filed under this subchapter,

(iii) copies of statements of ownership under section 1320a–3 of this title, and

(iv) information disclosed under section 1320a–5 of this title.

(B) Notices of substandard care

If a State finds that—

(i) a provider of home or community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this subchapter, or

(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

(C) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

(j) Enforcement process for providers of community care

(1) State authority

(A) In general

If a State finds, on the basis of a review under subsection (i)(2) or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

(B) Civil money penalty

(i) In general

Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(ii) Deadline and guidance

Each State which elects to provide home and community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

(2) Secretarial authority

(A) For State providers

With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under

this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

(B) Other providers

With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

(C) Civil money penalty

If the Secretary finds on the basis of a review under subsection (i)(2) or otherwise that a home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(k) Secretarial responsibilities

(1) Publication of interim requirements

(A) In general

The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including—

(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified case managers), of subsection (f) (relating to minimum requirements for home and community care), of subsection (g) (relating to minimum requirements for small community care settings), and of subsection (h) (relating to minimum requirements for large community care settings), and

(ii) survey protocols (for use under subsection (i)(3)(A)) which relate to such requirements.

(B) Minimum protections

Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(2) Development of final requirements

The Secretary shall develop, by not later than October 1, 1992—

(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

(3) No delegation to States

The Secretary's authority under this subsection shall not be delegated to States.

(4) No prevention of more stringent requirements by States

Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(*l*) Waiver of Statewideness

States may waive the requirement of section 1396a(a)(1) of this title (related to Statewideness) for a program of home and community care under this section.

(m) Limitation on amount of expenditures as medical assistance

(1) Limitation on amount

The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $40,000,000, for fiscal year 1992, $70,000,000, for fiscal year 1993, $130,000,000, for fiscal year 1994, $160,000,000, and for fiscal year 1995, $180,000,000.

(2) Assurance of entitlement to service

A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) to individuals described in subsection (b) for the duration of the election period, without regard to the amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by the State, and approved by the Secretary, for the provision of home and community care under this section.

(3) Limitation on eligibility

The State may limit eligibility for home and community care under this section during an

election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

(4) Allocation of medical assistance

The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State's election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals.

(Aug. 14, 1935, ch. 531, title XIX, § 1929, as added Pub. L. 101–508, title IV, § 4711(b), Nov. 5, 1990, 104 Stat. 1388–174; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(v)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398.)

Editorial Notes

CODIFICATION

Pub. L. 101–508, title IV, § 4711(b)(1), Nov. 5, 1990, 104 Stat. 1388–174, which directed renumbering of section 1929 of the Social Security Act, act Aug. 14, 1935, as section 1930, could not be executed because there was no section 1929.

AMENDMENTS

1999—Subsec. (c)(2)(E)(i), (ii). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(v)(1)], realigned margins.

Subsec. (k)(1)(A)(i). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(v)(2)], substituted ''large community care settings),'' for ''large community care settings,''.

Subsec. (*l*). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(v)(3)], substituted ''Statewideness'' for ''State wideness''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section 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 made 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 an Effective Date of 1990 Amendment note under section 1396a of this title.

§ 1396u. Community supported living arrangements services

(a) Community supported living arrangements services

In this subchapter, the term ''community supported living arrangements services'' means one or more of the following services meeting the requirements of subsection (h) provided in a State eligible to provide services under this section (as defined in subsection (d)) to assist a developmentally disabled individual (as defined in subsection (b)) in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

(1) Personal assistance.

(2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

(3) 24-hour emergency assistance (as defined by the Secretary).

(4) Assistive technology.

(5) Adaptive equipment.

(6) Other services (as approved by the Secretary, except those services described in subsection (g)).

(7) Support services necessary to aid an individual to participate in community activities.

(b) "Developmentally disabled individual" defined

In this subchapter the term,[1] ''developmentally disabled individual'' means an individual who as defined by the Secretary is described within the term ''mental retardation and related conditions'' as defined in regulations as in effect on July 1, 1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

(c) Criteria for selection of participating States

The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

(d) Quality assurance

A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that—

(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

(2) the State will adopt standards for survey and certification that include—

(A) minimum qualifications and training requirements for provider staff;

(B) financial operating standards; and

(C) a consumer grievance process;

(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

(4) the State will establish reporting procedures to make available information to the public;

(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

(6) the State will provide the services defined in subsection (a) in accordance with an individual support plan (as defined by the Secretary in regulations); and

[1] So in original. The comma probably should precede ''the term''.

(7) the State plan amendment under this section shall be reviewed by the State Council on Developmental Disabilities established under section 125 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. §15025] and the protection and advocacy system established under subtitle C of that Act [42 U.S.C. 15041 et seq.].

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

(e) Maintenance of effort

States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

(f) Excluded services

No Federal financial participation shall be allowed for the provision of the following services under this section:

(1) Room and board.

(2) Cost of prevocational, vocational and supported employment.

(g) Waiver of requirements

The Secretary may waive such provisions of this subchapter as necessary to carry out the provisions of this section including the following requirements of this subchapter—

(1) comparability of amount, duration, and scope of services; and

(2) statewideness.

(h) Minimum protections

(1) Publication of interim and final requirements

(A) In general

The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

(B) Minimum protections

Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d), that—

(i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

(ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

(2) Specified remedies

If the Secretary finds that a provider has not met an applicable requirement under subsection (h), the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(i) Treatment of funds

Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

(j) Limitation on amounts of expenditures as medical assistance

The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $5,000,000, for fiscal year 1992, $10,000,000, for fiscal year 1993, $20,000,000, for fiscal year 1994, $30,000,000, for fiscal year 1995, $35,000,000, and for fiscal years thereafter such sums as provided by Congress.

(Aug. 14, 1935, ch. 531, title XIX, §1930, as added Pub. L. 101–508, title IV, §4712(b), Nov. 5, 1990, 104 Stat. 1388–187; amended Pub. L. 106–402, title IV, §401(b)(6)(B), Oct. 30, 2000, 114 Stat. 1738.)

Editorial Notes

REFERENCES IN TEXT

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (d)(7), is Pub. L. 106–402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of the Act probably means subtitle C of title I of the Act, which is classified generally to part C (§15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

CODIFICATION

Pub. L. 101–508, title IV, §4712(b)(1), Nov. 5, 1990, 104 Stat. 1388–187, which directed renumbering of section 1930 of the Social Security Act, act Aug. 14, 1935, as section 1931, could not be executed because there was no section 1930.

AMENDMENTS

2000—Subsec. (d)(7). Pub. L. 106–402 substituted ''State Council on Developmental Disabilities established under section 125 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and the protection and advocacy system established under subtitle C of that Act'' for ''State Planning Council established under section 6024 of this title, and the Protection and Advocacy System established under section 6042 of this title''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 101–508, title IV, §4712(c), Nov. 5, 1990, 104 Stat. 1388–190, provided that:

''(1) IN GENERAL.—The amendments made by this section [enacting this section and amending section 1396d of this title] shall apply 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 subsection (h) [probably means 42 U.S.C. 1396u(h)] without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

''(2) APPLICATION PROCESS.—The Secretary of Health and Human Services shall provide that the applications required to be submitted by States under this section shall be received and approved prior to the effective date specified in paragraph (1).''

§ 1396u–1. Assuring coverage for certain low-income families

(a) References to subchapter IV–A are references to pre-welfare-reform provisions

Subject to the succeeding provisions of this section, with respect to a State any reference in this subchapter (or any other provision of law in relation to the operation of this subchapter) to a provision of part A of subchapter IV, or a State plan under such part (or a provision of such a plan), including income and resource standards and income and resource methodologies under such part or plan, shall be considered a reference to such a provision or plan as in effect as of July 16, 1996, with respect to the State.

(b) Application of pre-welfare-reform eligibility criteria

(1) In general

For purposes of this subchapter, subject to paragraphs (2) and (3), in determining eligibility for medical assistance—

(A) an individual shall be treated as receiving aid or assistance under a State plan approved under part A of subchapter IV only if the individual meets—

(i) the income and resource standards for determining eligibility under such plan, and

(ii) the eligibility requirements of such plan under subsections (a) through (c) of section 606 of this title and section 607(a) of this title,

as in effect as of July 16, 1996; and

(B) the income and resource methodologies under such plan as of such date shall be used in the determination of whether any individual meets income and resource standards under such plan.

(2) State option

For purposes of applying this section, a State—

(A) may lower its income standards applicable with respect to part A of subchapter IV, but not below the income standards applicable under its State plan under such part on May 1, 1988;

(B) may increase income or resource standards under the State plan referred to in paragraph (1) over a period (beginning after July 16, 1996) by a percentage that does not exceed the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) over such period; and

(C) may use income and resource methodologies that are less restrictive than the methodologies used under the State plan under such part as of July 16, 1996.

(3) Option to terminate medical assistance for failure to meet work requirement

(A) Individuals receiving cash assistance under TANF

In the case of an individual who—

(i) is receiving cash assistance under a State program funded under part A of subchapter IV,

(ii) is eligible for medical assistance under this subchapter on a basis not related to section 1396a(*l*) of this title, and

(iii) has the cash assistance under such program terminated pursuant to section 607(e)(1)(B) of this title (as in effect on or after the welfare reform effective date) because of refusing to work,

the State may terminate such individual's eligibility for medical assistance under this subchapter until such time as there no longer is a basis for the termination of such cash assistance because of such refusal.

(B) Exception for children

Subparagraph (A) shall not be construed as permitting a State to terminate medical assistance for a minor child who is not the head of a household receiving assistance under a State program funded under part A of subchapter IV.

(c) Treatment for purposes of transitional coverage provisions

(1) Transition in the case of child support collections

The provisions of section 606(h) of this title (as in effect on July 16, 1996) shall apply, in relation to this subchapter, with respect to individuals (and families composed of individuals) who are described in subsection (b)(1)(A), in the same manner as they applied before such date with respect to individuals who became ineligible for aid to families with dependent children as a result (wholly or partly) of the collection of child or spousal support under part D of subchapter IV.

(2) Transition in the case of earnings from employment

For continued medical assistance in the case of individuals (and families composed of individuals) described in subsection (b)(1)(A) who would otherwise become ineligible because of hours or income from employment, see sections 1396r–6 and 1396a(e)(1) of this title.

(d) Waivers

In the case of a waiver of a provision of part A of subchapter IV in effect with respect to a State as of July 16, 1996, or which is submitted to the Secretary before August 22, 1996, and approved by the Secretary on or before July 1, 1997, if the waiver affects eligibility of individuals for medical assistance under this subchapter, such waiver may (but need not) continue to be applied, at the option of the State, in relation to this subchapter after the date the waiver would otherwise expire.

(e) State option to use 1 application form

Nothing in this section, or part A of subchapter IV, shall be construed as preventing a State from providing for the same application form for assistance under a State program funded under part A of subchapter IV (on or after the welfare reform effective date) and for medical assistance under this subchapter.

(f) Additional rules of construction

(1) With respect to the reference in section 1396a(a)(5) of this title to a State plan approved under part A of subchapter IV, a State may treat such reference as a reference either to a State program funded under such part (as in effect on and after the welfare reform effective date) or to the State plan under this subchapter.

(2) Any reference in section 1396a(a)(55) of this title to a State plan approved under part A of subchapter IV shall be deemed a reference to a State program funded under such part.

(3) In applying section 1396b(f) of this title, the applicable income limitation otherwise determined shall be subject to increase in the same manner as income or resource standards of a State may be increased under subsection (b)(2)(B).

(g) Relation to other provisions

The provisions of this section shall apply notwithstanding any other provision of this chapter.

(h) Transitional increased Federal matching rate for increased administrative costs

(1) In general

Subject to the succeeding provisions of this subsection, the Secretary shall provide that with respect to administrative expenditures described in paragraph (2) the per centum specified in section 1396b(a)(7) of this title shall be increased to such percentage as the Secretary specifies.

(2) Administrative expenditures described

The administrative expenditures described in this paragraph are expenditures described in section 1396b(a)(7) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs of eligibility determinations that (but for the enactment of this section) would not be incurred.

(3) Limitation

The total amount of additional Federal funds that are expended as a result of the application of this subsection for the period beginning with fiscal year 1997 shall not exceed $500,000,000. In applying this paragraph, the Secretary shall ensure the equitable distribution of additional funds among the States.

(i) Welfare reform effective date

In this section, the term ''welfare reform effective date'' means the effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act).

(Aug. 14, 1935, ch. 531, title XIX, §1931, as added Pub. L. 104–193, title I, §114(a)(2), Aug. 22, 1996, 110 Stat. 2177; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §602(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394.)

Editorial Notes

REFERENCES IN TEXT

For effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act), referred to in subsec. (i), see section 116 of Pub. L. 104–193, set out as an Effective Date note under section 601 of this title.

PRIOR PROVISIONS

A prior section 1931 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

1999—Subsec. (h)(3). Pub. L. 106–113, §1000(a)(6) [title VI, §602(a)(1)], struck out ''and ending with fiscal year 2000'' after ''fiscal year 1997''.

Subsec. (h)(4). Pub. L. 106–113, §1000(a)(6) [title VI, §602(a)(2)], struck out heading and text of par. (4). Prior to amendment, text read as follows: ''This subsection shall only apply with respect to a State for expenditures incurred during the first 12 calendar quarters in which the State program funded under part A of subchapter IV of this chapter (as in effect on and after the welfare reform effective date) is in effect.''

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §602(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, provided that: ''The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177).''

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§1396u–2. Provisions relating to managed care

(a) State option to use managed care

(1) Use of medicaid managed care organizations and primary care case managers

(A) In general

Subject to the succeeding provisions of this section, and notwithstanding paragraph

(1), (10)(B), or (23)(A) of section 1396a(a) of this title, a State—

(i) may require an individual who is eligible for medical assistance under the State plan under this subchapter to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

(I) the entity and the contract with the State meet the applicable requirements of this section and section 1396b(m) of this title or section 1396d(t) of this title, and

(II) the requirements described in the succeeding paragraphs of this subsection are met; and

(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

(B) "Managed care entity" defined

In this section, the term ''managed care entity'' means—

(i) a medicaid managed care organization, as defined in section 1396b(m)(1)(A) of this title, that provides or arranges for services for enrollees under a contract pursuant to section 1396b(m) of this title; and

(ii) a primary care case manager, as defined in section 1396d(t)(2) of this title.

(2) Special rules

(A) Exemption of certain children with special needs

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

(i) is eligible for supplemental security income under subchapter XVI;

(ii) is described in section 701(a)(1)(D) of this title;

(iii) is described in section 1396a(e)(3) of this title;

(iv) is receiving foster care or adoption assistance under part E of subchapter IV; or

(v) is in foster care or otherwise in an out-of-home placement.

(B) Exemption of medicare beneficiaries

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) or an individual otherwise eligible for benefits under subchapter XVIII.

(C) Indian enrollment

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c)[1] of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

(i) The Indian Health Service.

(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act [25 U.S.C. 5321 et seq.].

(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(3) Choice of coverage

(A) In general

A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1396b(m) of this title or section 1396d(t) of this title.

(B) State option

At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity—

(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

(C) Treatment of certain county-operated health insuring organizations

A State shall be considered to meet the requirement of subparagraph (A) if—

(i) the managed care entity in which the individual is enrolled is a health-insuring organization which—

(I) first became operational prior to January 1, 1986, or

(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

(ii) the individual is given a choice between at least two providers within such entity.

(4) Process for enrollment and termination and change of enrollment

As conditions under paragraph (1)(A)—

(A) In general

The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the entity under this subchapter to terminate (or change) such enrollment—

[1] See References in Text note below.

(i) for cause at any time (consistent with section 1396b(m)(2)(A)(vi) of this title), and

(ii) without cause—

(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

(II) at least every 12 months thereafter.

(B) Notice of termination rights

The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

(C) Enrollment priorities

In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

(D) Default enrollment process

In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of section 1396b(m) of this title or section 1396d(t) of this title; and

(ii) that takes into consideration—

(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this subchapter; and

(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

(5) Provision of information

(A) Information in easily understood form

Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this subchapter in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this subchapter.

(B) Information to enrollees and potential enrollees

Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

(i) Providers

The identity, locations, qualifications, and availability of health care providers that participate with the organization.

(ii) Enrollee rights and responsibilities

The rights and responsibilities of enrollees.

(iii) Grievance and appeal procedures

The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

(iv) Information on covered items and services

All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

(C) Comparative information

A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

(i) Benefits and cost-sharing

The benefits covered and cost-sharing imposed by the entity.

(ii) Service area

The service area of the entity.

(iii) Quality and performance

To the extent available, quality and performance indicators for the benefits under the entity.

(D) Information on benefits not covered under managed care arrangement

A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this subchapter, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this subchapter but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

(b) Beneficiary protections

(1) Specification of benefits

Each contract with a managed care entity under section 1396b(m) of this title or under

section 1396d(t)(3) of this title shall specify the benefits the provision (or arrangement) for which the entity is responsible.

(2) Assuring coverage to emergency services

(A) In general

Each contract with a medicaid managed care organization under section 1396b(m) of this title and each contract with a primary care case manager under section 1396d(t)(3) of this title shall require the organization or manager—

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

(ii) to comply with guidelines established under section 1395w–22(d)(2) of this title (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of subchapter XVIII.

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

(B) "Emergency services" defined

In subparagraph (A)(i), the term ''emergency services'' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) "Emergency medical condition" defined

In subparagraph (B)(ii), the term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(D) Emergency services furnished by non-contract providers

Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

(3) Protection of enrollee-provider communications

(A) In general

Subject to subparagraphs (B) and (C), under a contract under section 1396b(m) of this title a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) Construction

Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(C) "Health care professional" defined

For purposes of this paragraph, the term ''health care professional'' means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse

specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Grievance procedures

Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this subchapter, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

(5) Demonstration of adequate capacity and services

Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(6) Protecting enrollees against liability for payment

Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the organization may not be held liable—

(A) for the debts of the organization, in the event of the organization's insolvency,

(B) for services provided to the individual—

(i) in the event of the organization failing to receive payment from the State for such services; or

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

(7) Antidiscrimination

A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

(8) Compliance with certain maternity and mental health requirements

Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act[1] insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage. In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a Medicaid managed care organization (or a prepaid inpatient health plan (as defined by the Secretary) or prepaid ambulatory health plan (as defined by the Secretary) that offers services to enrollees of a Medicaid managed care organization) shall be treated as in compliance with such requirements if the Medicaid managed care organization (or prepaid inpatient health plan or prepaid ambulatory health plan) is in compliance with subpart K of part 438 of title 42, Code of Federal Regulations, and section 438.3(n) of such title, or any successor regulation.

(c) Quality assurance standards

(1) Quality assessment and improvement strategy

(A) In general

If a State provides for contracts with medicaid managed care organizations under section 1396b(m) of this title, the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

(i) Access standards

Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

(ii) Other measures

Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

(iii) Monitoring procedures

Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of subchapter XVIII or such alternative data as the Secretary approves, in consultation with the State.

(iv) Periodic review

Regular, periodic examinations of the scope and content of the strategy.

(B) Standards

The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after August 5, 1997. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1396n(b)(1) of this title shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

(C) Monitoring

The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

(D) Consultation

The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

(2) External independent review of managed care activities

(A) Review of contracts

(i) In general

Each contract under section 1396b(m) of this title with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

(ii) Qualifications of reviewer

The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

(iii) Use of protocols

The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

(iv) Availability of results

The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

(B) Nonduplication of accreditation

A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1395w–22(e)(4) of this title) or that has an external review conducted under section 1395w–22(e)(3) of this title, the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

(C) Deemed compliance for medicare managed care organizations

At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1395mm of this title or a Medicare+Choice organization with a contract in effect under part C of subchapter XVIII and the organization has had a contract in effect under section 1396b(m) of this title at least during the previous 2-year period.

(d) Protections against fraud and abuse

(1) Prohibiting affiliations with individuals debarred by Federal agencies

(A) In general

A managed care entity may not knowingly—

(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

(B) Effect of noncompliance

If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

(i) shall notify the Secretary of such noncompliance;

(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(C) Persons described

A person is described in this subparagraph if such person—

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order

No. 12549 or under guidelines implementing such order; or

(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

(2) Restrictions on marketing

(A) Distribution of materials

(i) In general

A managed care entity, with respect to activities under this subchapter, may not distribute directly or through any agent or independent contractor marketing materials within any State—

(I) without the prior approval of the State, and

(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

(ii) Consultation in review of market materials

In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(B) Service market

A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1396b(m) of this title or section 1396d(t)(3) of this title.

(C) Prohibition of tie-ins

A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

(D) Prohibiting marketing fraud

Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

(E) Prohibition of "cold-call" marketing

Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other ''cold-call'' marketing of enrollment under this subchapter.

(3) State conflict-of-interest safeguards in medicaid risk contracting

A medicaid managed care organization may not enter into a contract with any State under section 1396b(m) of this title unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under chapter 21 of title 41, against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

(4) Use of unique physician identifier for participating physicians

Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this subchapter to have a unique identifier in accordance with the system established under section 1320d–2(b) of this title.

(5) Contract requirement for managed care entities

With respect to any contract with a managed care entity under section 1396b(m) or 1396d(t)(3) of this title (as applicable), no later than July 1, 2018, such contract shall include a provision that providers of services or persons terminated (as described in section 1396a(kk)(8) of this title) from participation under this subchapter, subchapter XVIII, or subchapter XXI shall be terminated from participating under this subchapter as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this subchapter.

(6) Enrollment of participating providers

(A) In general

Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this subchapter (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1396a(kk) of this title with the State agency administering the State plan under this subchapter. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

(B) Rule of construction

Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this subchapter.

(e) Sanctions for noncompliance

(1) Use of intermediate sanctions by the State to enforce requirements

(A) In general

A State may not enter into or renew a contract under section 1396b(m) of this title unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid man-

aged care organization with such a contract, if the organization—

(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this subchapter;

(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this subchapter, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subchapter; or

(II) to an enrollee, potential enrollee, or a health care provider under such subchapter; or

(v) fails to comply with the applicable requirements of section 1396b(m)(2)(A)(x) of this title.

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II).

(B) Rule of construction

Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

(2) Intermediate sanctions

The sanctions described in this paragraph are as follows:

(A) Civil money penalties as follows:

(i) Except as provided in clause (ii), (iii), or (iv), not more than $25,000 for each determination under paragraph (1)(A).

(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than $100,000 for each such determination.

(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

(B) The appointment of temporary management—

(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

(I) there is an orderly termination or reorganization of the organization; or

(II) improvements are made to remedy the violations found under paragraph (1),

except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

(D) Suspension or default of all enrollment of individuals under this subchapter after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of section 1396b(m) of this title or this section.

(E) Suspension of payment to the entity under this subchapter for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Treatment of chronic substandard entities

In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1396b(m) of this title and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

(4) Authority to terminate contract

(A) In general

In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1396b(m) or 1396d(t)(3) of this title, the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this subchapter other than through a managed care entity).

(B) Availability of hearing prior to termination of contract

A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

(C) Notice and right to disenroll in cases of termination hearing

A State may—

(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

(ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

(5) Other protections for managed care entities against sanctions imposed by State

Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).

(f) Timeliness of payment; adequacy of payment for primary care services

A contract under section 1396b(m) of this title with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this subchapter who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) of this title, unless the health care provider and the organization agree to an alternate payment schedule and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation).

(g) Identification of patients for purposes of making DSH payments

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require the entity either—

(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1395ww(d)(5)(F) and 1396r–4 of this title; or

(2) to include a sponsorship code in the identification card issued to individuals covered under this subchapter in order that a hospital may identify a patient as being entitled to benefits under this subchapter.

(h) Special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities

(1) Enrollee option to select an Indian health care provider as primary care provider

In the case of a non-Indian Medicaid managed care entity that—

(A) has an Indian enrolled with the entity; and

(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

(2) Assurance of payment to Indian health care providers for provision of covered services

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

(A) Demonstration of access to Indian health care providers and application of alternative payment arrangements

Subject to subparagraph (C), to—

(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

(B) Prompt payment

To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1396u–2(f) of this title) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

(C) Application of special payment requirements for federally-qualified health centers and for services provided by certain Indian health care providers

(i) Federally-qualified health centers

(I) Managed care entity payment requirement

To agree to pay any Indian health care provider that is a federally-qualified health center under this subchapter but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

(II) Continued application of State requirement to make supplemental payment

Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1396a(bb)(5) of this title regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the federally-qualified health center is or is not a participating provider with the entity).

(ii) Payment rate for services provided by certain Indian health care providers

If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

(D) Construction

Nothing in this paragraph shall be construed as waiving the application of section 1396a(a)(30)(A) of this title (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(3) Special rule for enrollment for Indian managed care entities

Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

(4) Definitions

For purposes of this subsection:

(A) Indian health care provider

The term ''Indian health care provider'' means an Indian Health Program or an Urban Indian Organization.

(B) Indian Medicaid managed care entity

The term ''Indian Medicaid managed care entity'' means a managed care entity that is controlled (within the meaning of the last sentence of section 1396b(m)(1)(C) of this title) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(C) Non-Indian Medicaid managed care entity

The term ''non-Indian Medicaid managed care entity'' means a managed care entity that is not an Indian Medicaid managed care entity.

(D) Covered Medicaid managed care services

The term ''covered Medicaid managed care services'' means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(E) Medicaid managed care program

The term ''Medicaid managed care program'' means a program under sections 1396b(m), 1396d(t), and 1396u–2 of this title and includes a managed care program operating under a waiver under section 1396n(b) or 1315 of this title or otherwise.

(i) Drug utilization review activities and requirements

Beginning not later than October 1, 2019, each contract under a State plan with a managed care entity (other than a primary care case manager) under section 1396b(m) of this title shall provide that the entity is in compliance with the applicable provisions of section 438.3(s)(2) of title 42, Code of Federal Regulations, section 483.3(s)(4))[2] of such title, and section 483.3(s)(5)[3] of such title, as such provisions were in effect on March 31, 2018.

(Aug. 14, 1935, ch. 531, title XIX, § 1932, as added and amended Pub. L. 105–33, title IV, §§ 4701(a), 4704(a), 4705(a), 4707(a), 4708(c), Aug. 5, 1997, 111 Stat. 489, 495, 498, 501, 506; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(w)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 106–554, § 1(a)(6) [title VII, § 701(b)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570; Pub. L. 109–171, title VI, § 6085(a), Feb. 8, 2006, 120 Stat. 121; Pub. L. 111–5, div. B, title V, § 5006(d)(1), Feb. 17, 2009, 123 Stat. 507; Pub. L. 111–152, title I, § 1202(a)(2), Mar. 30, 2010, 124 Stat. 1053; Pub. L. 114–255, div. A, title V, § 5005(a)(2),

[2] So in original. Probably should be section ''438.3(s)(4)'' and second parenthesis probably should not appear.

[3] So in original. Probably should be section ''438.3(s)(5)''.

(b)(2), Dec. 13, 2016, 130 Stat. 1192, 1193; Pub. L. 115–271, title I, §1004(a)(3), Oct. 24, 2018, 132 Stat. 3911; Pub. L. 116–260, div. BB, title II, §203(a)(4)(A), Dec. 27, 2020, 134 Stat. 2917; Pub. L. 117–328, div. FF, title V, §5123(a), Dec. 29, 2022, 136 Stat. 5944.)

AMENDMENT OF SUBSECTION (a)(5)

Pub. L. 117–328, div. FF, title V, §5123(a), (d), Dec. 29, 2022, 136 Stat. 5944, 5946, provided that, effective July 1, 2025, subsection (a)(5) of this section is amended as follows:

(1) in subparagraph (B)(i), by inserting '', including as required by subparagraph (E)'' before the period at the end; and

(2) by adding at the end the following new subparagraph:

(E) Provider directories

(i) In general

Each managed care organization, prepaid inpatient health plan (as defined by the Secretary), prepaid ambulatory health plan (as defined by the Secretary), and, when appropriate, primary care case management entity (as defined by the Secretary) with a contract with a State to enroll individuals who are eligible for medical assistance under the State plan under this subchapter or under a waiver of such plan, shall publish (and update on at least a quarterly basis or more frequently as required by the Secretary) on a public website, a searchable directory of network providers, which shall include physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports as appropriate, and such other providers as required by the Secretary, and that includes with respect to each such provider—

(I) the name of the provider;

(II) the specialty of the provider;

(III) the address at which the provider provides services;

(IV) the telephone number of the provider; and

(V) information regarding—

(aa) the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office;

(bb) whether the provider is accepting as new patients, individuals who receive medical assistance under this subchapter;

(cc) whether the provider's office or facility has accommodations for individuals with physical disabilities, including offices, exam rooms, and equipment;

(dd) the Internet website of such provider, if applicable; and

(ee) whether the provider offers covered services via telehealth; and

(VI) other relevant information, as required by the Secretary.

(ii) Network provider defined

In this subparagraph, the term ''network provider'' includes any provider, group of providers, or entity that has a network provider agreement with a managed care organization, a prepaid inpatient health plan (as defined by the Secretary), a prepaid ambulatory health plan (as defined by the Secretary), or a primary care case management entity (as defined by the Secretary) or a subcontractor of any such entity or plan, and receives payment under this subchapter directly or indirectly to order, refer, or render covered services as a result of the State's contract with the entity or plan. For purposes of this subparagraph, a network provider shall not be considered to be a subcontractor by virtue of the network provider agreement.

See 2022 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

Section 4(c) of the Indian Health Care Improvement Act of 1976, referred to in subsec. (a)(2)(C), probably means section 4(c) of the Indian Health Care Improvement Act, which was redesignated section 4(13) of the Act by Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935, and is classified to section 1603(13) of Title 25, Indians.

The Indian Self-Determination Act, referred to in subsec. (a)(2)(C)(ii), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (a)(2)(C)(iii), 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.

Section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(3)(C)(i)(II), is section 9517(c)(3) of Pub. L. 99–272, which is set out as a note under section 1396b of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (b)(3)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (b)(8), is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart 2 of part A of title XXVII of the Act may refer to subpart II of part A of subchapter XXV of chapter 6A of this title. Pub. L. 111–148, title I, §§1001(5), 1563(c)(2), (11), formerly §1562(c)(2), (11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 268, 911, amended part A by inserting ''SUBPART II—IMPROVING COVERAGE'' (preceding section 300gg–11 of this title), by striking out ''SUBPART 2—OTHER REQUIREMENTS'' (preceding section 300gg–4 of this title), and by redesignating subpart 4 as subpart 2 ''EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION'' (preceding section 300gg–21 of this title). For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Executive Order No. 12549, referred to in subsec. (d)(1)(C)(i), is set out as a note under section 6101 of Title 31, Money and Finance.

CODIFICATION

In subsec. (d)(3), ''chapter 21 of title 41'' substituted for ''section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423)'' on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1932 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2022—Subsec. (a)(5)(B)(i). Pub. L. 117–328, § 5123(a)(1), inserted ‘‘, including as required by subparagraph (E)’’ before period at end.

Subsec. (a)(5)(E). Pub. L. 117–328, § 5123(a)(2), added subpar. (E).

2020—Subsec. (b)(8). Pub. L. 116–260 inserted at end ‘‘In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a Medicaid managed care organization (or a prepaid inpatient health plan (as defined by the Secretary) or prepaid ambulatory health plan (as defined by the Secretary) that offers services to enrollees of a Medicaid managed care organization) shall be treated as in compliance with such requirements if the Medicaid managed care organization (or prepaid inpatient health plan or prepaid ambulatory health plan) is in compliance with subpart K of part 438 of title 42, Code of Federal Regulations, and section 438.3(n) of such title, or any successor regulation.’’

2018—Subsec. (i). Pub. L. 115–271 added subsec. (i).

2016—Subsec. (d)(5). Pub. L. 114–255, § 5005(a)(2), added par. (5).

Subsec. (d)(6). Pub. L. 114–255, § 5005(b)(2), added par. (6).

2010—Subsec. (f). Pub. L. 111–152 inserted ‘‘; adequacy of payment for primary care services’’ after ‘‘payment’’ in heading and ‘‘and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)’’ before period at end of text.

2009—Subsec. (h). Pub. L. 111–5 added subsec. (h).

2006—Subsec. (b)(2)(D). Pub. L. 109–171 added subpar. (D).

2000—Subsec. (g). Pub. L. 106–554 added subsec. (g).

1999—Subsec. (c)(2)(C). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(w)(1)], inserted ‘‘part’’ before ‘‘C of subchapter XVIII’’.

Subsec. (d)(1)(C)(ii). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(w)(2)(A)], substituted ‘‘Regulation’’ for ‘‘Act’’.

Subsec. (d)(2)(B). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(w)(2)(B)], substituted ‘‘1396d(t)(3) of this title’’ for ‘‘1396b(t)(3) of this title’’.

1997—Subsec. (b). Pub. L. 105–33, § 4704(a), added subsec. (b).

Subsec. (c). Pub. L. 105–33, § 4705(a), added subsec. (c).

Subsecs. (d), (e). Pub. L. 105–33, § 4707(a), added subsecs. (d) and (e).

Subsec. (f). Pub. L. 105–33, § 4708(c), added subsec. (f).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 effective July 1, 2025, see section 5123(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, § 6085(b), Feb. 8, 2006, 120 Stat. 121, provided that: ‘‘The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2007.’’

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title VII, § 701(b)(3)(A)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570, provided that: ‘‘The amendment made by paragraph (1) [amending this section] shall apply to contracts as of January 1, 2001.’’

EFFECTIVE DATE

Section effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, except that, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, subsec. (c)(1) effective Jan. 1, 1999, and subsec. (e) applicable to contracts entered into or renewed on or after Apr. 1, 1998, see section 4710(a), (b)(3), (5) of Pub. L. 105–33, set out as an Effective Date of 1997 Amendment note under section 1396b of this title.

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by Pub. L. 114–255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114–255, set out as a note under section 1396a of this title.

STUDIES AND REPORTS

Pub. L. 105–33, title IV, § 4705(c), Aug. 5, 1997, 111 Stat. 500, provided that:

‘‘(1) GAO STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—

‘‘(A) STUDY.—The Comptroller General of the United States shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector, or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall determine—

‘‘(i) if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals; and

‘‘(ii) the appropriateness of applying such programs and standards to medicaid managed care organizations under section 1932(c) of such Act [42 U.S.C. 1396u–2(c)].

‘‘(B) REPORT.—The Comptroller General shall submit a report to the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

‘‘(2) STUDY AND REPORT ON SERVICES PROVIDED TO INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.—

‘‘(A) STUDY.—The Secretary of Health and Human Services, in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled with medicaid managed care organizations are adequately met.

‘‘(B) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall submit to Committees described in paragraph (1)(B) a report on such study.’’

§ 1396u–3. State coverage of medicare cost-sharing for additional low-income medicare beneficiaries

(a) In general

A State plan under this subchapter shall provide, under section 1396a(a)(10)(E)(iv) of this

title and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as ''qualifying individuals'') who are selected to receive such assistance under subsection (b).

(b) Selection of qualifying individuals

A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

(1) All qualifying individuals may apply

The State shall permit all qualifying individuals to apply for assistance during a calendar year.

(2) Selection on first-come, first-served basis

(A) In general

For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

(B) Carryover

For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1396a(a)(10)(E) of this title) in the last month of the previous year and who continue to be (or become) qualifying individuals.

(3) Limit on number of individuals based on allocation

The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

(4) Receipt of assistance during duration of year

If a qualifying individual is selected to receive assistance under this section for a month in a year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

(c) Allocation

(1) Total allocation

The total amount available for allocation under this section for—

(A) fiscal year 1998 is $200,000,000;

(B) fiscal year 1999 is $250,000,000;

(C) fiscal year 2000 is $300,000,000;

(D) fiscal year 2001 is $350,000,000; and

(E) each of fiscal years 2002 and 2003 is $400,000,000.

(2) Allocation to States

The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

(A) an amount equal to the total number of individuals described in section 1396a(a)(10)(E)(iv) of this title in the State; to

(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

(d) Applicable FMAP

With respect to assistance described in section 1396a(a)(10)(E)(iv) of this title furnished in a State for calendar quarters in a calendar year—

(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.

(e) Limitation on entitlement

Except as specifically provided under this section, nothing in this subchapter shall be construed as establishing any entitlement of individuals described in section 1396a(a)(10)(E)(iv) of this title to assistance described in such section.

(f) Coverage of costs through part B of medicare program

For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title to the appropriate account in the Treasury that provides for payments under section 1396b(a) of this title with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of section 1395r of this title.

(g) Special rules

(1) In general

With respect to each period described in paragraph (2), a State shall select qualifying individuals, subject to paragraph (3), and provide such individuals with assistance, in accordance with the provisions of this section as in effect with respect to calendar year 2003, except that for such purpose—

(A) references in the preceding subsections of this section to a year, whether fiscal or calendar, shall be deemed to be references to such period; and

(B) the total allocation amount under subsection (c) for such period shall be the amount described in paragraph (2) for that period.

(2) Periods and total allocation amounts described

For purposes of this subsection—

(A) for the period that begins on January 1, 2008, and ends on September 30, 2008, the total allocation amount is $315,000,000;

(B) for the period that begins on October 1, 2008, and ends on December 31, 2008, the total allocation amount is $130,000,000;

(C) for the period that begins on January 1, 2009, and ends on September 30, 2009, the total allocation amount is $350,000,000;

(D) for the period that begins on October 1, 2009, and ends on December 31, 2009, the total allocation amount is $150,000,000;

(E) for the period that begins on January 1, 2010, and ends on September 30, 2010, the total allocation amount is $462,500,000;

(F) for the period that begins on October 1, 2010, and ends on December 31, 2010, the total allocation amount is $165,000,000;

(G) for the period that begins on January 1, 2011, and ends on September 30, 2011, the total allocation amount is $720,000,000;

(H) for the period that begins on October 1, 2011, and ends on December 31, 2011, the total allocation amount is $280,000,000;

(I) for the period that begins on January 1, 2012, and ends on September 30, 2012, the total allocation amount is $450,000,000;

(J) for the period that begins on October 1, 2012, and ends on December 31, 2012, the total allocation amount is $280,000,000;

(K) for the period that begins on January 1, 2013, and ends on September 30, 2013, the total allocation amount is $485,000,000;

(L) for the period that begins on October 1, 2013, and ends on December 31, 2013, the total allocation amount is $300,000,000;

(M) for the period that begins on January 1, 2014, and ends on September 30, 2014, the total allocation amount is $485,000,000;

(N) for the period that begins on October 1, 2014, and ends on December 31, 2014, the total allocation amount is $300,000,000;

(O) for the period that begins on January 1, 2015, and ends on March 31, 2015, the total allocation amount is $250,000,000;

(P) for the period that begins on April 1, 2015, and ends on December 31, 2015, the total allocation amount is $535,000,000; and

(Q) for 2016 and, subject to paragraph (4), for each subsequent year, the total allocation amount is $980,000,000.

(3) Rules for periods that begin after January 1

For any specific period described in subparagraph (B), (D), (F), (H), (J), (L), (N), or (P) of paragraph (2), the following applies:

(A) The specific period shall be treated as a continuation of the immediately preceding period in that calendar year for purposes of applying subsection (b)(2) and qualifying individuals who received assistance in the last month of such immediately preceding period shall be deemed to be selected for the specific period (without the need to complete an application for assistance for such period).

(B) The limit to be applied under subsection (b)(3) for the specific period shall be the same as the limit applied under such subsection for the immediately preceding period.

(C) The ratio to be applied under subsection (c)(2) for the specific period shall be the same as the ratio applied under such subsection for the immediately preceding period.

(4) Adjustment to allocations

The Secretary may increase the allocation amount under paragraph (2)(Q) for a year (beginning with 2017) up to an amount that does not exceed the product of the following:

(A) Maximum allocation amount for previous year

In the case of 2017, the allocation amount for 2016, or in the case of a subsequent year, the maximum allocation amount allowed under this paragraph for the previous year.

(B) Increase in part B premium

The monthly premium rate determined under section 1395r of this title for the year divided by the monthly premium rate determined under such section for the previous year.

(C) Increase in part B enrollment

The average number of individuals (as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services in September of the previous year) to be enrolled under part B of subchapter XVIII for months in the year divided by the average number of such individuals (as so estimated) under this subparagraph with respect to enrollments in months in the previous year.

(Aug. 14, 1935, ch. 531, title XIX, § 1933, as added Pub. L. 105–33, title IV, § 4732(c), Aug. 5, 1997, 111 Stat. 520; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 608(x)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 108–89, title IV, § 401(b), (c), Oct. 1, 2003, 117 Stat. 1134; Pub. L. 108–173, title I, § 103(f)(2), Dec. 8, 2003, 117 Stat. 2160; Pub. L. 108–448, § 1(b), Dec. 8, 2004, 118 Stat. 3467; Pub. L. 109–91, title I, § 101(b), Oct. 20, 2005, 119 Stat. 2091; Pub. L. 110–90, § 3(b), Sept. 29, 2007, 121 Stat. 984; Pub. L. 110–173, title II, § 203(b), Dec. 29, 2007, 121 Stat. 2513; Pub. L. 110–275, title I, § 111(b), July 15, 2008, 122 Stat. 2503; Pub. L. 110–379, § 2, Oct. 8, 2008, 122 Stat. 4075; Pub. L. 111–5, div. B, title V, § 5005(b), Feb. 17, 2009, 123 Stat. 505; Pub. L. 111–127, § 3, Jan. 27, 2010, 124 Stat. 4; Pub. L. 111–309, title I, § 110(b), Dec. 15, 2010, 124 Stat. 3288; Pub. L. 112–78, title III, § 310(b), Dec. 23, 2011, 125 Stat. 1286; Pub. L. 112–96, title III, § 3101(b), Feb. 22, 2012, 126 Stat. 191; Pub. L. 112–240, title VI, § 621(b), Jan. 2, 2013, 126 Stat. 2352; Pub. L. 113–67, div. B, title II, § 1201(b), Dec. 26, 2013, 127 Stat. 1198; Pub. L. 113–93, title II, § 201(b), Apr. 1, 2014, 128 Stat. 1045; Pub. L. 114–10, title II, § 211(b), Apr. 16, 2015, 129 Stat. 151.)

Editorial Notes

PRIOR PROVISIONS

A prior section 1933 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2015—Subsec. (g)(2). Pub. L. 114–10, § 211(b)(1), redesignated subpars. (I) to (W) as (A) to (O), respectively, added subpars. (P) and (Q), and struck out former subpars. (A) to (H) which related to total allocation amounts for various periods beginning on January 1, 2004, and ending on December 31, 2007.

Subsec. (g)(3). Pub. L. 114–10, §211(b)(2), substituted ''or (P)'' for ''(P), (R), (T), or (V)'' in introductory provisions.

Subsec. (g)(4). Pub. L. 114–10, §211(b)(3), added par. (4).

2014—Subsec. (g)(2)(T). Pub. L. 113–93, §201(b)(1)(A), struck out ''and'' at end.

Subsec. (g)(2)(U). Pub. L. 113–93, §201(b)(1)(B), substituted ''September 30, 2014'' for ''March 31, 2014'' and ''$485,000,000;'' for ''$200,000,000.''

Subsec. (g)(2)(V), (W). Pub. L. 113–93, §201(b)(1)(C), added subpars. (V) and (W).

Subsec. (g)(3). Pub. L. 113–93, §201(b)(2), substituted ''(T), or (V)'' for ''or (T)'' in introductory provisions.

2013—Subsec. (g)(2)(S), (T). Pub. L. 112–240, §621(b)(1), added subpars. (S) and (T).

Subsec. (g)(2)(U). Pub. L. 113–67 added subpar. (U).

Subsec. (g)(3). Pub. L. 112–240, §621(b)(2), substituted ''(R), or (T)'' for ''or (R)'' in introductory provisions.

2012—Subsec. (g)(2)(Q), (R). Pub. L. 112–96, §3101(b)(1), substituted ''September 30, 2012, the total allocation amount is $450,000,000; and'' for ''February 29, 2012, the total allocation amount is $150,000,000.'' in subpar. (Q) and added subpar. (R).

Subsec. (g)(3). Pub. L. 112–96, §3101(b)(2), substituted ''(P), or (R)'' for ''or (P)'' in introductory provisions.

2011—Subsec. (g)(2)(Q). Pub. L. 112–78 added subpar. (Q).

2010—Subsec. (g)(2)(M). Pub. L. 111–127, §3(1), substituted ''$462,500,000'' for ''$412,500,000''.

Subsec. (g)(2)(N). Pub. L. 111–127, §3(2), substituted ''$165,000,000'' for ''$150,000,000''.

Subsec. (g)(2)(O), (P). Pub. L. 111–309, §110(b)(1), added subpars. (O) and (P).

Subsec. (g)(3). Pub. L. 111–309, §110(b)(2), substituted ''(N), or (P)'' for ''or (N)'' in introductory provisions.

2009—Subsec. (g)(2)(M), (N). Pub. L. 111–5, §5005(b)(1), added subpars. (M) and (N).

Subsec. (g)(3). Pub. L. 111–5, §5005(b)(2), substituted ''(L), or (N)'' for ''or (L)'' in introductory provisions.

2008—Subsec. (g)(2)(I). Pub. L. 110–379, §2(1), substituted ''$315,000,000'' for ''$300,000,000''.

Pub. L. 110–275, §111(b)(1)(B)(i), (ii), substituted ''September 30'' for ''June 30'' and ''$300,000,000'' for ''$200,000,000''.

Subsec. (g)(2)(J). Pub. L. 110–379, §2(2), substituted ''$130,000,000'' for ''$100,000,000''.

Pub. L. 110–275, §111(b)(1)(A), (B)(iii), (C), added subpar. (J).

Subsec. (g)(2)(K), (L). Pub. L. 110–275, §111(b)(1)(C), added subpars. (K) and (L).

Subsec. (g)(3). Pub. L. 110–275, §111(b)(2), substituted ''(H), (J), or (L)'' for ''or (H)'' in introductory provisions.

2007—Subsec. (g)(2)(H). Pub. L. 110–90, §3(b)(1), added subpar. (H).

Subsec. (g)(2)(I). Pub. L. 110–173 added subpar. (I).

Subsec. (g)(3). Pub. L. 110–90, §3(b)(2), substituted ''(F), or (H)'' for ''or (F)'' in introductory provisions.

2005—Subsec. (g)(2)(D) to (G). Pub. L. 109–91, §101(b)(1), added subpars. (D) to (G).

Subsec. (g)(3). Pub. L. 109–91, §101(b)(2), inserted '', (D), or (F)'' after ''subparagraph (B)'' in introductory provisions.

2004—Subsec. (g). Pub. L. 108–448 amended heading and text of subsec. (g) generally. Prior to amendment, text read as follows: ''With respect to the period that begins on January 1, 2004, and ends on September 30, 2004, a State shall select qualifying individuals, and provide such individuals with assistance, in accordance with the provisions of this section as in effect with respect to calendar year 2003, except that for such purpose—

''(1) references in the preceding subsections of this section to 'fiscal year' and 'calendar year' shall be deemed to be references to such period; and

''(2) the total allocation amount under subsection (c) of this section for such period shall be $300,000,000.''

2003—Subsec. (c)(1)(E). Pub. L. 108–89, §401(b)(1), substituted ''each of fiscal years 2002 and 2003'' for ''fiscal year 2002''.

Subsec. (c)(2)(A). Pub. L. 108–89, §401(b)(2), substituted ''the total number of individuals described in section 1396a(a)(10)(E)(iv) of this title in the State; to'' for ''the sum of—

''(i) twice the total number of individuals described in section 1396a(a)(10)(E)(iv)(I) of this title in the State, and

''(ii) the total number of individuals described in section 1396a(a)(10)(E)(iv)(II) of this title in the State; to''.

Subsec. (g). Pub. L. 108–173, §103(f)(2)(A), substituted ''September 30, 2004'' for ''March 31, 2004'' in introductory provisions.

Pub. L. 108–89, §401(c), added subsec. (g).

Subsec. (g)(2). Pub. L. 108–173, §103(f)(2)(B), substituted ''$300,000,000'' for ''$100,000,000''.

1999—Subsec. (b)(4). Pub. L. 106–113 inserted ''a'' after ''for a month in''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2007 AMENDMENT

Amendment by Pub. L. 110–90 effective as of Sept. 30, 2007, see section 3(c) of Pub. L. 110–90, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2005 AMENDMENT

Amendment by Pub. L. 109–91 effective Sept. 30, 2005, see section 101(c) of Pub. L. 109–91, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to calendar quarters beginning on or after Apr. 1, 2004, see section 103(f)(3) of Pub. L. 108–173, set out as a note under section 1396a of this title.

§ 1396u–4. Program of all-inclusive care for elderly (PACE)

(a) State option

(1) In general

A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of subchapter XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.

(2) "PACE program" defined

For purposes of this section, the term ''PACE program'' means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) "PACE provider" defined

(A) In general

For purposes of this section, the term ''PACE provider'' means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) "PACE program agreement" defined

For purposes of this section, the term ''PACE program agreement'' means, with respect to a PACE provider, an agreement, consistent with this section, section 1395eee of this title (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) "PACE program eligible individual" defined

For purposes of this section, the term ''PACE program eligible individual'' means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) "PACE protocol" defined

For purposes of this section, the term ''PACE protocol'' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) "PACE demonstration waiver program" defined

For purposes of this section, the term ''PACE demonstration waiver program'' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) "State administering agency" defined

For purposes of this section, the term ''State administering agency'' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this subchapter in the State) responsible for administering PACE program agreements under this section and section 1395eee of this title in the State.

(9) "Trial period" defined

(A) In general

For purposes of this section, the term ''trial period'' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) Treatment of entities previously operating PACE demonstration waiver programs

Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) "Regulations" defined

For purposes of this section, the term ''regulations'' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1395eee of this title.

(b) Scope of benefits; beneficiary safeguards

(1) In general

Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals, regardless of source of payment and

directly or under contracts with other entities, at a minimum—

(i) all items and services covered under subchapter XVIII (for individuals enrolled under section 1395eee of this title) and all items and services covered under this subchapter, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such subchapter or this subchapter, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) Quality assurance; patient safeguards

The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this subchapter and Federal and State law designed for the protection of patients.

(3) Treatment of medicare services furnished by noncontract physicians and other entities

(A) Application of medicare advantage requirement with respect to medicare services furnished by noncontract physicians and other entities

Section 1395w–22(k)(1) of this title (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under subchapter XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) Reference to related provision for noncontract providers of services

For the provision relating to limitations on balance billing against PACE providers for services covered under subchapter XVIII furnished by noncontract providers of services, see section 1395cc(a)(1)(O) of this title.

(4) Reference to related provision for services covered under this subchapter but not under subchapter XVIII

For provisions relating to limitations on payments to providers participating under the State plan under this subchapter that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under subchapter XVIII) when such services are furnished to enrollees of that PACE provider, see section 1396a(a)(67) of this title.

(c) Eligibility determinations

(1) In general

The determination of—

(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

(B) who is entitled to medical assistance under this subchapter shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) Condition

An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

(3) Annual eligibility recertifications

(A) In general

Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

(B) Exception

The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases in which the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) Continuation of eligibility

An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets

the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) Enrollment; disenrollment

(A) Voluntary disenrollment at any time

The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) Limitations on disenrollment

(i) In general

Regulations promulgated by the Secretary under this section and section 1395eee of this title, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) No disenrollment for noncompliant behavior

Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term ''noncompliant behavior'' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) Timely review of proposed nonvoluntary disenrollment

A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) Payments to PACE providers on a capitated basis

(1) In general

In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

(2) Capitation amount

The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1395eee of this title for individuals who are enrolled in a PACE program under such section.

(e) PACE program agreement

(1) Requirement

(A) In general

The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1395eee of this title, and regulations.

(B) Numerical limitation

(i) In general

The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of August 5, 1997, or

(II) as of each succeeding anniversary of August 5, 1997, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) Treatment of certain private, for-profit providers

The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h), or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) Service area and eligibility

(A) In general

A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) Service area overlap

In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) Data collection; development of outcome measures

(A) Data collection

(i) In general

Under a PACE program agreement, the PACE provider shall—

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

(ii) Requirements during trial period

During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) Development of outcome measures

Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) Oversight

(A) Annual, close oversight during trial period

During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an onsite visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or the State administering agency considers necessary or appropriate.

(B) Continuing oversight

After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) Disclosure

The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) Termination of PACE provider agreements

(A) In general

Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

(B) Causes for termination

In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1395eee of this title; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) Termination and transition procedures

An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) Secretary's oversight; enforcement authority

(A) In general

Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1395eee of this title with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) Application of intermediate sanctions

Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1395w–27(g)(2) (or, for periods before January 1, 1999, section 1395mm(i)(6)(B) of this title) or 1396b(m)(5)(B) of this title in the case of violations by the provider of the type described in section 1395w–27(g)(1) (or 1395mm(i)(6)(A) of this title for such periods) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under section 1395eee of this title or this section, respectively).

(7) Procedures for termination or imposition of sanctions

Under regulations, the provisions of section 1395w–27(h) of this title (or for periods before January 1, 1999, section 1395mm(i)(9) of this title) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C of subchapter XVIII (or for such periods an eligible organization under section 1395mm of this title).

(8) Timely consideration of applications for PACE program provider status

In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) Regulations

(1) In general

The Secretary shall issue interim final or final regulations to carry out this section and section 1395eee of this title.

(2) Use of PACE protocol

(A) In general

In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) Flexibility

In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1395eee of this title, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long-term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(C) Continuation of modifications or waivers of operational requirements under demonstration status

If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1[1] 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.

(3) Application of certain additional beneficiary and program protections

(A) In general

In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of subchapter XVIII (or, for periods before

[1] So in original. Probably should be followed by a comma.

January 1, 1999, section 1395mm of this title) and sections 1396b(m) and 1396u–2 of this title relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1395mm of this title) and to medicaid managed care organizations under prepaid capitation agreements under section 1396b(m) of this title.

(B) Considerations

In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C of subchapter XVIII (or, for periods before January 1, 1999, section 1395mm of this title) and section 1396b(m) of this title;

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this subchapter or subchapter XVIII.

(4) Construction

Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) Waivers of requirements

With respect to carrying out a PACE program under this section, the following requirements of this subchapter (and regulations relating to such requirements) shall not apply:

(1) Section 1396a(a)(1) of this title, relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

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

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

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

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

(h) Demonstration project for for-profit entities

(1) In general

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

(2) Similar terms and conditions

(A) In general

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

(B) Numerical limitation

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

(i) Post-eligibility treatment of income

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

(j) Miscellaneous provisions

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

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

Editorial Notes

REFERENCES IN TEXT

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

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

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

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

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

For the effective date of this section, referred to in subsec. (a)(9)(B), see section 4803 of Pub. L. 105–33, set

out as a Transition; Regulations note under section 1395eee of this title.

PRIOR PROVISIONS

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

AMENDMENTS

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

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

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2003 AMENDMENT

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

EFFECTIVE DATE OF 2000 AMENDMENT

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

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

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

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

(1) Information for transitional prescription drug assistance verification

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

(2) Eligibility determinations for low-income subsidies

The State shall—

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

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

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

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

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

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

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

(b) Regular Federal subsidy of administrative costs

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

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

(1) Phased-down State contribution

(A) In general

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

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

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

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

(B) Form and manner of payment

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

(C) Compliance

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

Federal Claims Collection Act of 1996[1] and applicable regulations.

(D) Data match

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

(2) Amount

(A) In general

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

(i) 1/12 of the product of—

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

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

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

(B) Notice

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

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

(A) In general

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

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

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

(B) Gross per capita medicaid expenditures for prescription drugs

(i) In general

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

(ii) Determination

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

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

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

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

(iii) Adjustment factor

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

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

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

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

(C) Weighted average

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

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

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

(4) Applicable growth factor

The applicable growth factor under this paragraph for—

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

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

(5) Factor

The factor under this paragraph for a month—

(A) in 2006 is 90 percent;

[1] See References in Text note below.

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

(6) Full-benefit dual eligible individual defined

(A) In general

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

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

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

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

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

(d) Coordination of prescription drug benefits

(1) Medicare as primary payor

In the case of a part D eligible individual (as defined in section 1395w–101(a)(3)(A) of this title) who is described in subsection (c)(6)(A)(ii), notwithstanding any other provision of this subchapter, medical assistance is not available under this subchapter for such drugs (or for any cost-sharing respecting such drugs), and the rules under this subchapter relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this subchapter. No payment may be made under section 1396b(a) of this title for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

(2) Coverage of certain excludable drugs

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

(e) Treatment of territories

(1) In general

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

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

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

(2) Plan

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

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

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

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

(3) Increased amount

(A) In general

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

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

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

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

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

(B) Aggregate amount

The aggregate amount specified in this subparagraph for—

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

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

(iii) a subsequent year, is equal to the aggregate amount specified in this sub-

paragraph for the previous year increased by annual percentage increase specified in section 1395w–102(b)(6) of this title for the year involved.

(4) Treatment of funding for certain fiscal years

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

(5) Report

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

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

Editorial Notes

REFERENCES IN TEXT

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

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

PRIOR PROVISIONS

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

AMENDMENTS

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

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

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

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

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

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

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

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

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

EFFECTIVE DATE OF 2005 AMENDMENT

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

§ 1396u–6. Medicaid Integrity Program

(a) In general

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

(b) Activities described

Activities described in this subsection are as follows:

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

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

(A) cost reports;

(B) consulting contracts; and

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

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

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

(c) Eligible entity and contracting requirements

(1) In general

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

(2) Eligibility requirements

The requirements of this paragraph are the following:

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

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

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

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

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

(3) Contracting requirements

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

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

(B) Competitive procedures to be used—

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

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

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

(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(4) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

(d) Comprehensive plan for program integrity

(1) 5-year plan

With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this subchapter by combatting fraud, waste, and abuse.

(2) Consultation

Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this subchapter.

(e) Appropriation

(1) In general

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section (including the costs of equipment, salaries and benefits, and travel and training), without further appropriation—

(A) for fiscal year 2006, $5,000,000;

(B) for each of fiscal years 2007 and 2008, $50,000,000;

(C) for each of fiscal years 2009 and 2010, $75,000,000; and

(D) for each fiscal year after fiscal year 2010, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(2) Availability; authority for use of funds

(A) Availability

Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

(B) Authority for use of funds for transportation and travel expenses for attendees at education, training, or consultative activities

(i) In general

The Secretary may use amounts appropriated pursuant to paragraph (1) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5 while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend

education, training, or consultative activities conducted under the authority of that subsection.

(ii) Public disclosure

The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

(I) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

(II) the amount of funds expended for each such conference that were for transportation and for travel expenses.

(3) Increase in CMS staffing devoted to protecting Medicaid program integrity

From the amounts appropriated under paragraph (1), the Secretary shall increase by 100, or such number as determined necessary by the Secretary to carry out the Program, the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

(4) Evaluations

The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(5) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(Aug. 14, 1935, ch. 531, title XIX, §1936, as added Pub. L. 109–171, title VI, §6034(a)(2), Feb. 8, 2006, 120 Stat. 74; amended Pub. L. 110–379, §5(a)(1), (b)(1), Oct. 8, 2008, 122 Stat. 4078; Pub. L. 111–148, title VI, §6402(j)(2), Mar. 23, 2010, 124 Stat. 762; Pub. L. 111–152, title I, §1303(b), Mar. 30, 2010, 124 Stat. 1058; Pub. L. 114–115, §6, Dec. 28, 2015, 129 Stat. 3133.)

Editorial Notes

REFERENCES IN TEXT

Section 202(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(B)(ii), is section 202(b) of title II of Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1998, which amended sections 1395h and 1395u of this title.

PRIOR PROVISIONS

A prior section 1936 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2015—Subsec. (a). Pub. L. 114–115, §6(1), inserted ‘‘, or otherwise,’’ after ‘‘entities’’.

Subsec. (e)(1). Pub. L. 114–115, §6(2)(A), inserted ‘‘(including the costs of equipment, salaries and benefits, and travel and training)’’ after ‘‘Program under this section’’ in introductory provisions.

Subsec. (e)(3). Pub. L. 114–115, §6(2)(B), substituted ‘‘by 100, or such number as determined necessary by the Secretary to carry out the Program,’’ for ‘‘by 100’’.

2010—Subsec. (c)(2)(D), (E). Pub. L. 111–148, §6402(j)(2)(A), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (e)(1)(C). Pub. L. 111–152, §1303(b)(2)(A), substituted ‘‘for each of fiscal years 2009 and 2010’’ for ‘‘for each fiscal year thereafter’’.

Subsec. (e)(1)(D). Pub. L. 111–152, §1303(b)(1), (2)(B), (3), added subpar. (D).

Subsec. (e)(4), (5). Pub. L. 111–148, §6402(j)(2)(B), added par. (4) and redesignated former par. (4) as (5).

2008—Subsec. (b)(4). Pub. L. 110–379, §5(a)(1)(A), substituted ‘‘Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this subchapter,’’ for ‘‘Education of’’.

Subsec. (e)(2). Pub. L. 110–379, §5(a)(1)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: ‘‘Amounts appropriated pursuant to paragraph (1) shall remain available until expended.’’

Subsec. (e)(2)(B)(ii). Pub. L. 110–379, §5(b)(1), added cl. (ii).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–379, §5(a)(2), Oct. 8, 2008, 122 Stat. 4078, provided that: ‘‘The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of section 1936 of the Social Security Act [42 U.S.C. 1396u–6], as added by section 6034(a) of the Deficit Reduction Act of 2005 (Public Law 109–171).’’

Pub. L. 110–379, §5(b)(2), Oct. 8, 2008, 122 Stat. 4079, provided that: ‘‘The amendment made by paragraph (1) [amending this section] shall apply to conferences conducted under the authority of section 1936(b)(4) of the Social Security Act (42 U.S.C. 1396u–6(b)(4)) after the date of enactment of this Act [Oct. 8, 2008].’’

§ 1396u–7. State flexibility in benefit packages

(a) State option of providing benchmark benefits

(1) Authority

(A) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability) and any other provision of this subchapter which would be directly contrary to the authority under this section and subject to subparagraphs (E) and (F), a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to individuals within one or more groups of individuals specified by the State through coverage that—

(i) provides benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

(ii) for any individual described in section 1396d(a)(4)(B) of this title who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1396a(a) of this title, consists of the items and services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in ac-

cordance with the requirements of section 1396a(a)(43) of this title.

(B) Limitation

The State may only exercise the option under subparagraph (A) for an individual eligible under subclause (VIII) of section 1396a(a)(10)(A)(i) of this title or under an eligibility category that had been established under the State plan on or before February 8, 2006.

(C) Option of additional benefits

In the case of coverage described in subparagraph (A), a State, at its option, may provide such additional benefits as the State may specify.

(D) Treatment as medical assistance

Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1396d(a) of this title.

(E) Rule of construction

Nothing in this paragraph shall be construed as—

(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

(iii) affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1396d of this title and provided in accordance with section 1396a(a)(43) of this title whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.

(F) Necessary transportation

Notwithstanding the preceding provisions of this paragraph, a State may not provide medical assistance through the enrollment of an individual with benchmark coverage or benchmark equivalent coverage described in subparagraph (A)(i) unless, subject to section 1396b(i)(9) of this title and in accordance with section 1396a(a)(4) of this title, the benchmark benefit package or benchmark equivalent coverage (or the State)—

(i) ensures necessary transportation for individuals enrolled under such package or coverage to and from providers; and

(ii) provides a description of the methods that will be used to ensure such transportation.

(2) Application

(A) In general

Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this subchapter through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

(B) Limitation on application

A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

(i) Mandatory pregnant women

The individual is a pregnant woman who is required to be covered under the State plan under section 1396a(a)(10)(A)(i) of this title.

(ii) Blind or disabled individuals

The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1396a(e)(3) of this title.

(iii) Dual eligibles

The individual is entitled to benefits under any part of subchapter XVIII.

(iv) Terminally ill hospice patients

The individual is terminally ill and is receiving benefits for hospice care under this subchapter.

(v) Eligible on basis of institutionalization

The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Medically frail and special medical needs individuals

The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

(vii) Beneficiaries qualifying for long-term care services

The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1396p(c)(1)(C) of this title.

(viii) Children in foster care receiving child welfare services and children receiving foster care or adoption assistance

The individual is an individual with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or with respect to whom adoption or foster care assistance is made available

under part E of such subchapter, without regard to age, or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title.

(ix) TANF and section 1396u–1 parents

The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of subchapter IV (as in effect on or after the welfare reform effective date defined in section 1396u–1(i) of this title).

(x) Women in the breast or cervical cancer program

The individual is a woman who is receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(xi) Limited services beneficiaries

The individual—

(I) qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(ii)(XII) of this title; or

(II) is not a qualified alien (as defined in section 1641 of title 8) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1396b(v) of this title.

(C) Full-benefit eligible individuals

(i) In general

For purposes of this paragraph, subject to clause (ii), the term ''full-benefit eligible individual'' means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1396d(a) of this title which are covered under the State plan under this subchapter for such month under section 1396a(a)(10)(A) of this title or under any other category of eligibility for medical assistance for all such services under this subchapter, as determined by the Secretary.

(ii) Exclusion of medically needy and spend-down populations

Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1396a(a)(10)(C) of this title or by reason of section 1396a(f) of this title or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

(b) Benchmark benefit packages

(1) In general

For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-equivalent health insurance coverage

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5.

(B) State employee coverage

A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(C) Coverage offered through HMO

The health insurance coverage plan that—

(i) is offered by a health maintenance organization (as defined in section 300gg–91(b)(3) of this title), and

(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(D) Secretary-approved coverage

Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

(2) Benchmark-equivalent coverage

For purposes of subsection (a)(1), subject to paragraphs (5) and (6)[1] coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the following categories of basic services:

(i) Inpatient and outpatient hospital services.

(ii) Physicians' surgical and medical services.

(iii) Laboratory and x-ray services.

(iv) Coverage of prescription drugs.

(v) Mental health services.

(vi) Well-baby and well-child care, including age-appropriate immunizations.

(vii) Other appropriate preventive services, as designated by the Secretary.

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

(C) Substantial actuarial value for additional services included in benchmark package

With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

(i) Vision services.

(ii) Hearing services.

(3) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

(A) by an individual who is a member of the American Academy of Actuaries;

[1] So in original. Probably should be followed by a comma.

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of the population involved;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this subchapter that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(4) Coverage of rural health clinic and FQHC services

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless—

(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1396d(a)(2) of this title; and

(B) payment for such services is made in accordance with the requirements of section 1396a(bb) of this title.

(5) Minimum standards

Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 18022(b) of this title, and beginning January 1, 2022, coverage of routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial (as defined in section 1396d(gg) of this title).

(6) Mental health services parity

(A) In general

In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 300gg–26(a) of this title in the same manner as such requirements apply to a group health plan. In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a benchmark benefit package or benchmark equivalent coverage described in such sentence shall be treated as in compliance with such requirements if the State plan under this subchapter or the benchmark benefit package or benefit equivalent coverage, as applicable, is in compliance with subpart C of part 440 of title 42, Code of Federal Regulations, or any successor regulation.

(B) Deemed compliance

Coverage provided with respect to an individual described in section 1396d(a)(4)(B) of this title and covered under the State plan under section 1396a(a)(10)(A) of this title of the services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with section 1396a(a)(43) of this title, shall be deemed to satisfy the requirements of subparagraph (A).

(7) Coverage of family planning services and supplies

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1396d(a)(4)(C) of this title, medical assistance for family planning services and supplies in accordance with such section.

(8) COVID–19 vaccines, testing, and treatment

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless, during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, such coverage includes (and does not impose any deduction, cost sharing, or similar charge for)—

(A) COVID–19 vaccines and administration of the vaccines; and

(B) testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of such an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan).

(c) Publication of provisions affected

With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this

subchapter that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and[2] not later than 30 days after such date of approval.

(Aug. 14, 1935, ch. 531, title XIX, § 1937, as added Pub. L. 109–171, title VI, § 6044(a), Feb. 8, 2006, 120 Stat. 88; amended Pub. L. 111–3, title VI, § 611(a)–(c), Feb. 4, 2009, 123 Stat. 100, 101; Pub. L. 111–148, title II, §§ 2001(a)(5)(E), (c), 2004(c)(2), 2303(c), Mar. 23, 2010, 124 Stat. 275, 276, 283, 296; Pub. L. 116–260, div. BB, title II, § 203(a)(4)(B), div. CC, title II, §§ 209(a)(2), 210(c), Dec. 27, 2020, 134 Stat. 2917, 2986, 2991; Pub. L. 117–2, title IX, § 9811(a)(5), Mar. 11, 2021, 135 Stat. 211.)

Editorial Notes

PRIOR PROVISIONS

A prior section 1937 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2021—Subsec. (b)(8). Pub. L. 117–2 added par. (8).

2020—Subsec. (a)(1)(A). Pub. L. 116–260, § 209(a)(2)(A), substituted ''subparagraphs (E) and (F)'' for ''subsection (E)''.

Subsec. (a)(1)(F). Pub. L. 116–260, § 209(a)(2)(B), added subpar. (F).

Subsec. (b)(5). Pub. L. 116–260, § 210(c), inserted '', and beginning January 1, 2022, coverage of routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial (as defined in section 1396d(gg) of this title)'' before period at end.

Subsec. (b)(6)(A). Pub. L. 116–260, § 203(a)(4)(B), substituted ''requirements of section 300gg–26(a)'' for ''requirements of section 300gg–4(a)'' and inserted at end ''In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a benchmark benefit package or benchmark equivalent coverage described in such sentence shall be treated as in compliance with such requirements if the State plan under this subchapter or the benchmark benefit package or benefit equivalent coverage, as applicable, is in compliance with subpart C of part 440 of title 42, Code of Federal Regulations, or any successor regulation.''

2010—Subsec. (a)(1)(B). Pub. L. 111–148, § 2001(a)(5)(E), inserted ''subclause (VIII) of section 1396a(a)(10)(A)(i) of this title or under'' after ''eligible under''.

Subsec. (a)(2)(B)(viii). Pub. L. 111–148, § 2004(c)(2), inserted '', or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title'' before period at end.

Subsec. (b)(1). Pub. L. 111–148, § 2001(c)(1), inserted ''subject to paragraphs (5) and (6),'' before ''each of the following'' in introductory provisions.

Subsec. (b)(2). Pub. L. 111–148, § 2001(c)(2)(A), inserted ''subject to paragraphs (5) and (6)'' after ''subsection (a)(1),'' in introductory provisions.

Subsec. (b)(2)(A)(iv) to (vii). Pub. L. 111–148, § 2001(c)(2)(B), added cls. (iv) and (v) and redesignated former cls. (iv) and (v) as (vi) and (vii), respectively.

Subsec. (b)(2)(C). Pub. L. 111–148, § 2001(c)(2)(C), redesignated cls. (iii) and (iv) as (i) and (ii), respectively, and struck out former cls. (i) and (ii) which read as follows:

''(i) Coverage of prescription drugs.

''(ii) Mental health services.''

Subsec. (b)(5), (6). Pub. L. 111–148, § 2001(c)(3), added pars. (5) and (6).

Subsec. (b)(7). Pub. L. 111–148, § 2303(c), added par. (7).

2009—Subsec. (a)(1)(A). Pub. L. 111–3, § 611(a)(1)(A), in introductory provisions, substituted ''Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability) and any other provision of this subchapter which would be directly contrary to the authority under this section and subject to subsection (E)'' for ''Notwithstanding any other provision of this subchapter'' and ''coverage that'' for ''enrollment in coverage that provides''.

Subsec. (a)(1)(A)(i). Pub. L. 111–3, § 611(a)(1)(B), inserted ''provides'' before ''benchmark coverage''.

Subsec. (a)(1)(A)(ii). Pub. L. 111–3, § 611(a)(1)(C), added cl. (ii) and struck out former cl. (ii) which read as follows: ''for any child under 19 years of age who is covered under the State plan under section 1396a(a)(10)(A) of this title, wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title.''

Subsec. (a)(1)(C). Pub. L. 111–3, § 611(a)(2), substituted ''additional'' for ''wrap-around'' in heading and struck out ''wrap-around or'' before ''additional'' in text.

Subsec. (a)(1)(E). Pub. L. 111–3, § 611(a)(3), added subpar. (E).

Subsec. (a)(2)(B)(viii). Pub. L. 111–3, § 611(b), substituted ''child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or'' for ''aid or assistance is made available under part B of subchapter IV to children in foster care and individuals''.

Subsec. (c). Pub. L. 111–3, § 611(c), added subsec. (c).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 209(a)(2) of Pub. L. 116–260 effective Dec. 27, 2020, and applicable to transportation furnished on or after such date, see section 209(a)(4) of Pub. L. 116–260, set out as a note under section 1396a of this title.

Amendment by section 210(c) of Pub. L. 116–260 applicable with respect to items and services furnished on or after Jan. 1, 2022, see section 210(e) of Pub. L. 116–260, set out as a note under section 1308 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2004(c)(2) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(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 2303(c) 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.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–3, title VI, § 611(d), Feb. 4, 2009, 123 Stat. 101, provided that: ''The amendments made by subsections (a), (b), and (c) of this section [amending this section] shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].''

EFFECTIVE DATE

Pub. L. 109–171, title VI, § 6044(b), Feb. 8, 2006, 120 Stat. 92, provided that: ''The amendment made by subsection (a) [enacting this section] takes effect on March 31, 2006.''

§ 1396u–8. Health opportunity accounts

(a) Authority

(1) In general

Notwithstanding any other provision of this subchapter, the Secretary shall establish a

[2] So in original.

demonstration program under which States may provide under their State plans under this subchapter (including such a plan operating under a statewide waiver under section 1315 of this title) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a ''State demonstration program''.

(2) Initial demonstration

(A) In general

The demonstration program under this section shall begin on January 1, 2007. During the first 5 years of such program, the Secretary shall not approve more than 10 States to conduct demonstration programs under this section, with each State demonstration program covering 1 or more geographic areas specified by the State. After such 5-year period—

(i) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

(ii) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

(B) GAO report

(i) In general

Not later than 3 months after the end of the 5-year period described in subparagraph (A), the Comptroller General of the United States shall submit a report to Congress evaluating the demonstration programs conducted under this section during such period.

(ii) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Comptroller General of the United States, $550,000 for the period of fiscal years 2007 through 2010 to carry out clause (i).

(3) Approval

The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

(A) Creating patient awareness of the high cost of medical care.

(B) Providing incentives to patients to seek preventive care services.

(C) Reducing inappropriate use of health care services.

(D) Enabling patients to take responsibility for health outcomes.

(E) Providing enrollment counselors and ongoing education activities.

(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

(4) No requirement for statewideness

Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide[1] basis.

(b) Eligible population groups

(1) In general

A State demonstration program under this section shall specify the eligible population groups consistent with paragraphs (2) and (3).

(2) Eligibility limitations during initial demonstration period

During the initial 5 years of the demonstration program under this section, a State demonstration program shall not apply to any of the following individuals:

(A) Individuals who are 65 years of age or older.

(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this subchapter is based on such disability.

(C) Individuals who are eligible for medical assistance under this subchapter only because they are (or were within the previous 60 days) pregnant.

(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

(3) Additional limitations

A State demonstration program shall not apply to any individual within a category of individuals described in section 1396u–7(a)(2)(B) of this title.

(4) Limitations

(A) State option

This subsection shall not be construed as preventing a State from further limiting eligibility.

(B) On enrollees in Medicaid managed care organizations

Insofar as the State provides for eligibility of individuals who are enrolled in Medicaid managed care organizations, such individuals may participate in the State demonstration program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

[1] So in original. Probably should not be capitalized.

(i) In no case may the number of such individuals enrolled in the organization who participate in the program exceed 5 percent of the total number of individuals enrolled in such organization.

(ii) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

(5) Voluntary participation

An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

(6) 1-year moratorium for reenrollment

An eligible individual who, for any reason, is disenrolled from a State demonstration program conducted under this section shall not be permitted to reenroll in such program before the end of the 1-year period that begins on the effective date of such disenrollment.

(c) Alternative benefits

(1) In general

The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this subchapter after an annual deductible described in paragraph (2) has been met; and

(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

(2) Annual deductible

The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(i)(II).

(3) Access to negotiated provider payment rates

(A) Fee-for-service enrollees

In the case of an individual who is participating in a State demonstration program and who is not enrolled with a Medicaid managed care organization, the State shall provide that the individual may obtain demonstration program Medicaid services from—

(i) any participating provider under this subchapter at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

(ii) any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this subchapter if the deductible described in paragraph (1)(A) was not applicable.

(B) Treatment under medicaid managed care plans

In the case of an individual who is participating in a State demonstration program and is enrolled with a Medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration program Medicaid services from any provider described in clause (ii) of subparagraph (A) at payment rates that do not exceed the payment rates that may be imposed under that clause.

(C) Computation

The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost sharing that would be otherwise applicable under sections 1396*o* and 1396*o*–1 of this title.

(D) Definitions

For purposes of this paragraph:

(i) The term ''demonstration program Medicaid services'' means, with respect to an individual participating in a State demonstration program, services for which the individual would be provided medical assistance under this subchapter but for the application of the deductible described in paragraph (1)(A).

(ii) The term ''participating provider'' means—

(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

(II) with respect to an individual described in subparagraph (B) who is enrolled in a Medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this subchapter.

(4) No effect on subsequent benefits

Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost sharing relating to such benefits.

(5) Overriding cost sharing and comparability requirements for alternative benefits

The provisions of this subchapter relating to cost sharing for benefits (including sections 1396*o* and 1396*o*–1 of this title) shall not apply

with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1396a(a)(10)(B) of this title (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

(6) Treatment as medical assistance

Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1396b(a) of this title.

(7) Use of tiered deductible and cost sharing

(A) In general

A State—

(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

(ii) may vary the amount of the maximum out-of-pocket cost sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

(B) Maximum out-of-pocket cost sharing

For purposes of subparagraph (A)(ii), the term ''maximum out-of-pocket cost sharing'' means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

(8) Contributions by employers

Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

(d) Health opportunity account

(1) In general

For purposes of this section, the term ''health opportunity account'' means an account that meets the requirements of this subsection.

(2) Contributions

(A) In general

No contribution may be made into a health opportunity account except—

(i) contributions by the State under this subchapter; and

(ii) contributions by other persons and entities, such as charitable organizations, as permitted under section 1396b(w) of this title.

(B) State contribution

A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

(C) Limitation on annual State contribution provided and permitting imposition of maximum account balance

(i) In general

A State—

(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

(ii) Indexing of dollar limitations

For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

(iii) Budget neutral adjustment

A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

(D) Limitations on Federal matching

(i) State contribution

A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under section 1396b(a) of this title with respect to contributions in excess of such limitations.

(ii) No FFP for private contributions

No Federal financial participation shall be provided under section 1396b(a) of this title with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

(E) Application of different matching rates

The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1396b(a) of this title exceeds the Fed-

eral medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

(3) Use

(A) General uses

(i) In general

Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

(ii) General limitation

Subject to subparagraph (B)(ii), in no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

(iii) State restrictions

In applying clause (i), a State may restrict payment for—

(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this subchapter or any other health benefit program, to have failed to meet quality standards or to have committed 1 or more acts of fraud or abuse; and

(II) items and services insofar as the State finds they are not medically appropriate or necessary.

(iv) Electronic withdrawals

The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

(B) Maintenance of health opportunity account after becoming ineligible for public benefit

(i) In general

Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this subchapter because of an increase in income or assets—

(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits, and such withdrawals shall be treated as medical assistance in accordance with subsection (c)(6).

(ii) Special rules

Withdrawals under this subparagraph from an account—

(I) shall be available for the purchase of health insurance coverage; and

(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

(iii) Exception from 25 percent savings to Government for private contributions

Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

(iv) Condition for non-health withdrawals

No withdrawal may be made from an account under clause (ii)(II) unless the account holder has participated in the program under this section for at least 1 year.

(v) No requirement for continuation of coverage

An account holder of a health opportunity account, after becoming ineligible for medical assistance under this subchapter, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

(4) Administration

A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1396b(a)(7) of this title.

(5) Treatment

Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this subchapter.

(6) Unauthorized withdrawals

A State may establish procedures—

(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

(B) to recoup costs that derive from such nonqualified withdrawals.

(Aug. 14, 1935, ch. 531, title XIX, §1938, as added Pub. L. 109–171, title VI, §6082(2), Feb. 8, 2006, 120 Stat. 113.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3) and (d)(3)(A)(ii), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1938 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

Statutory Notes and Related Subsidiaries

PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS

Pub. L. 111–3, title VI, § 613, Feb. 4, 2009, 123 Stat. 101, provided that: ''After the date of the enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u–8).''

§ 1396v. References to laws directly affecting medicaid program

(a) Authority or requirements to cover additional individuals

For provisions of law which make additional individuals eligible for medical assistance under this subchapter, see the following:

(1) AFDC

(A) Section 602(a)(32)[1] of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) Section 602(a)(37)[1] of this title (relating to individuals who lose AFDC eligibility due to increased earnings).

(C) Section 606(h)[1] of this title (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(D) Section 682(e)(6)[1] of this title (relating to certain individuals participating in work supplementation programs).

(2) SSI

(A) Section 1382(e) of this title (relating to treatment of couples sharing an accommodation in a facility).

(B) Section 1382h of this title (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(C) Section 1383c(b) of this title (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(D) Section 1383c(c) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 402(d) of this title).

(E) Section 1383c(d) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under section 402(e) or (f) of this title).

(3) Foster care and adoption assistance

Sections 672(h) and 673(b) of this title (relating to medical assistance for children in foster care and for adopted children).

(4) Refugee assistance

Section 1522(e)(5) of title 8 (relating to medical assistance for certain refugees).

(5) Miscellaneous

(A) Section 230 of Public Law 93–66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93–66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93–66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93–233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94–566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of Public Law 96–272 (relating to continuing medicaid eligibility for certain recipients of Department of Veterans Affairs pensions).

(b) Additional State plan requirements

For other provisions of law that establish additional requirements for State plans to be approved under this subchapter, see the following:

(1) Section 1382g of this title (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of Public Law 93–66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).

(Aug. 14, 1935, ch. 531, title XIX, § 1939, formerly § 1920, as added Pub. L. 99–272, title IX, § 9526, Apr. 7, 1986, 100 Stat. 218; renumbered § 1921, Pub. L. 99–509, title IX, § 9407(b), Oct. 21, 1986, 100 Stat. 2058; amended Pub. L. 99–514, title XVIII, § 1895(c)(5), Oct. 22, 1986, 100 Stat. 2936; Pub. L. 99–643, § 6(c), Nov. 10, 1986, 100 Stat. 3578; renumbered § 1922, Pub. L. 100–93, § 5(b), Aug. 18, 1987, 101 Stat. 690; renumbered § 1923 and § 1924 and amended Pub. L. 100–203, title IV, §§ 4112(a)(1), 4118(p)(9), 4211(a)(1), title IX, § 9116(d), Dec. 22, 1987, 101 Stat. 1330–148, 1330–159, 1330–182, 1330–306, as amended Pub. L. 100–360, title IV, § 411(k)(6)(B)(i), (10)(L), (n)(3), July 1, 1988, 102 Stat. 793, 797, as amended Pub. L. 100–485, title VI, § 608(d)(28), Oct. 13, 1988, 102 Stat. 2423; renumbered § 1925, Pub. L. 100–360, title III, § 303(a)(1)(A), July 1, 1988, 102 Stat. 754; renumbered § 1926 and amended Pub. L. 100–485, title II, § 202(c)(5), title III, § 303(a)(1), Oct. 13, 1988, 102 Stat. 2378, 2385; renumbered § 1927, Pub. L. 101–239, title VI, § 6402(b), Dec. 19, 1989, 103 Stat. 2260; renumbered § 1928, Pub. L. 101–508, title IV, § 4401(a)(3), Nov. 5, 1990, 104 Stat. 1388–143; Pub. L. 102–54, § 13(q)(3)(A)(v), June 13, 1991, 105 Stat. 279; renumbered § 1931, Pub. L. 103–66, title XIII, § 13631(b)(1), Aug. 10, 1993, 107 Stat. 637; renumbered § 1932, Pub. L. 104–193, title I, § 114(a)(1), Aug. 22, 1996, 110 Stat. 2177; renumbered §§ 1933, 1934, and 1935, Pub. L. 105–33, title IV, §§ 4701(a), 4732(c), 4802(a)(2), Aug. 5, 1997, 111 Stat. 489, 520, 538; renumbered § 1936, Pub. L. 108–173, title I, § 103(a)(2)(A), Dec. 8, 2003, 117 Stat. 2154; renumbered § 1937, renumbered § 1938, renumbered § 1939, Pub. L. 109–171, title VI, §§ 6034(a)(1), 6044(a), 6082(1), Feb. 8, 2006, 120 Stat. 74, 88, 113.)

[1] See References in Text note below.

Editorial Notes

REFERENCES IN TEXT

Section 602 of this title, referred to in subsec. (a)(1)(A), (B), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, subsec. (a) of section 602 no longer contains a par. (32) or (37).

Section 606 of this title, referred to in subsec. (a)(1)(C), 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. (h).

Section 682 of this title, referred to in subsec. (a)(1)(D), was repealed by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

Sections 230, 231, and 232 of Public Law 93–66, referred to in subsec. (a)(5)(A) to (C), are sections 230, 231, and 232 of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 159, 160, which are set out as notes under section 1396a of this title.

Section 13(c) of Public Law 93–233, referred to in subsec. (a)(5)(D), is section 13(c) of Pub. L. 93–233, Dec. 31, 1973, 87 Stat. 965, which is set out as a note under section 1396a of this title.

Section 503 of Public Law 94–566, referred to in subsec. (a)(5)(E), is section 503 of Pub. L. 94–566, title V, Oct. 20, 1976, 90 Stat. 2685, which is set out as a note under section 1396a of this title.

Section 310(b)(1) of Public Law 96–272, referred to in subsec. (a)(5)(F), is section 310(b)(1) of Pub. L. 96–272, title III, June 17, 1980, 94 Stat. 533, which is set out as a note under section 1396a of this title.

Section 212(a) of Public Law 93–66, referred to in subsec. (b)(2), is section 212(a) 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.

CODIFICATION

Section was formerly classified to section 1396s of this title prior to renumbering by Pub. L. 103–66.

AMENDMENTS

1991—Subsec. (a)(5)(F). Pub. L. 102–54 substituted ''Department of Veterans Affairs'' for ''Veterans' Administration''.

1988—Subsec. (a)(1). Pub. L. 100–360, §411(k)(10)(L), made technical correction to directory language of Pub. L. 100–203, §4118(p)(9), see 1987 Amendment note below.

Subsec. (a)(1)(D). Pub. L. 100–485, §202(c)(5), substituted ''section 682(e)(6) of this title'' for ''section 614(g) of this title''.

Subsec. (a)(2). Pub. L. 100–360, §411(k)(10)(L), made technical correction to directory language of Pub. L. 100–203, §4118(p)(9), see 1987 Amendment note below.

Subsec. (a)(2)(E). Pub. L. 100–360, §411(n)(3), as added by Pub. L. 100–485, §608(d)(28), amended Pub. L. 100–203, §9116(d), see 1987 Amendment note below.

1987—Subsec. (a)(1). Pub. L. 100–203, §4118(p)(9), as amended by Pub. L. 100–360, §411(k)(10)(L), amended par. (1) generally. Prior to amendment, par. (1) read as follows:

''(1) AFDC.—(A) Section 602(a)(32) of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made). Section 602(a)(37) of this title (relating to individuals who lose AFDC eligibility due to increased earnings).

''(C) Section 606(h) of this title (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

''(D) Section 614(g) of this title (relating to certain individuals participating in work supplementation programs).''

Subsec. (a)(2). Pub. L. 100–203, §4118(p)(9), as amended by Pub. L. 100–360, §411(k)(10)(L), amended par. (2) generally. Prior to amendment, par. (2) read as follows:

''(2) SSI.—(A) Section 1382h of this title (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

''(B) Section 1383c(b) of this title (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

''(B)[(C)] Section 1383c of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 402(d) of this title).''

Subsec. (a)(2)(E). Pub. L. 100–203, §9116(d), as amended generally by Pub. L. 100–360, §411(n)(3), as added by Pub. L. 100–485, §608(d)(28), added subpar. (E).

1986—Subsec. (a)(1). Pub. L. 99–514, §1895(c)(5)(A), redesignated subpars. (B) and (C) as (C) and (D), respectively, and inserted at beginning of subpar. (A) ''Section 602(a)(32) of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made).''

Subsec. (a)(2). Pub. L. 99–643, which directed amendment of section 1920(a)(2) of the Social Security Act by designating existing provisions as subpar. (A) and adding subpar. (B) relating to section 1383c of this title as it relates to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits, was executed to this section, section 1921 of the Social Security Act, to reflect the probable intent of Congress and the redesignation of section 1920 of the Social Security Act as section 1921 by Pub. L. 99–509.

Pub. L. 99–514, §1895(c)(5)(B), designated existing provisions as subpar. (A) and added subpar. (B) relating to section 1383c(b) of this title as it relates to preservation of benefit status for certain disabled widows and widowers.

Subsec. (a)(3). Pub. L. 99–514, §1895(c)(5)(C), substituted ''Sections 672(h) and 673(b) of this title'' for ''Section 673(b) of this title''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by section 202(c)(5) of Pub. L. 100–485 effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485, at such earlier effective dates, see section 204 of Pub. L. 100–485, set out as a note under section 671 of this title.

Amendment by section 608(d)(28) 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.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(6)(B)(i), (10)(L), (n)(3) 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.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

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.

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.

§ 1396w. Asset verification through access to information held by financial institutions

(a) Implementation

(1) In general

Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this subchapter.

(2) Plan submittal

In order to meet the requirement of paragraph (1), each State shall—

(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amendment under this subchapter that describes how the State intends to implement the asset verification program; and

(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

(3) Phase-in

(A) In general

(i) Implementation in current asset verification demo States

The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before June 30, 2008) to implement an asset verification program under this subsection by the end of fiscal year 2009.

(ii) Implementation in other States

The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of enrollees, in the aggregate for all such other States, by the end of the fiscal year involved:

(I) 12.5 percent by the end of fiscal year 2009.

(II) 25 percent by the end of fiscal year 2010.

(III) 50 percent by the end of fiscal year 2011.

(IV) 75 percent by the end of fiscal year 2012.

(V) 100 percent by the end of fiscal year 2013.

(iii) Implementation in Puerto Rico

The Secretary shall require Puerto Rico to implement an asset verification program under this subsection by January 1, 2026.

(B) Consideration

In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

(C) States specified

The States specified in this subparagraph are California, New York, and New Jersey.

(D) Construction

Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary from approving, the implementation of an asset verification program in advance of the deadline otherwise established under such subparagraph.

(4) Exemption of certain territories

This section shall only apply to the 50 States, the District of Columbia, and Puerto Rico.

(b) Asset verification program

(1) In general

For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

(A) requires each applicant for, or recipient of, medical assistance under the State plan under this subchapter on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act[1] [12 U.S.C. 3415] but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

(2) Program described

A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1383(e)(1)(B)(ii) of this title.

(c) Duration of authorization

Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act[1] [12 U.S.C. 3404(a)(1)], an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

[1] See References in Text note below.

(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this subchapter;

(2) the cessation of the recipient's eligibility for such medical assistance; or

(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

(d) Treatment of Right to Financial Privacy Act requirements

(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act[1] for purposes of section 1103(a) of such Act [12 U.S.C. 3403(a)], and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act [12 U.S.C. 3404(a)].

(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act[1] [12 U.S.C. 3403(b)] shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act[1] [12 U.S.C. 3404(a)(3)] and of section 1102 of such Act [12 U.S.C. 3402], relating to a reasonable description of financial records.

(e) Required disclosure

The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

(f) Refusal or revocation of authorization

If an applicant for, or recipient of, medical assistance under the State plan under this subchapter (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

(g) Use of contractor

For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with section 1396b(i)(2) of this title. In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

(h) Technical assistance

The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

(i) Reports

A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

(j) Treatment of program expenses

Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of section 1396b(a) of this title, in the same manner as State expenditures specified in paragraph (7) of such section.

(k) Reduction in FMAP after 2020 for non-compliant States

(1) In general

With respect to a calendar quarter, the Federal medical assistance percentage otherwise determined under section 1396d(b) of this title for—

(A) a non-compliant State that is one of the 50 States or the District of Columbia shall be reduced—

(i) for calendar quarters in 2021 and 2022, by 0.12 percentage points;

(ii) for calendar quarters in 2023, by 0.25 percentage points;

(iii) for calendar quarters in 2024, by 0.35 percentage points; and

(iv) for calendar quarters in 2025 and each year thereafter, by 0.5 percentage points; and

(B) a non-compliant State that is Puerto Rico shall be reduced—

(i) for calendar quarters in fiscal year 2026 beginning on or after January 1, 2026, by 0.12 percentage points;

(ii) for calendar quarters in fiscal year 2027, by 0.25 percentage points;

(iii) for calendar quarters in fiscal year 2028, by 0.35 percentage points; and

(iv) for calendar quarters in fiscal year 2029 and each fiscal year thereafter, by 0.5 percentage points.

(2) Non-compliant State defined

For purposes of this subsection, the term ''non-compliant State'' means a State—

(A) that is one of the 50 States, the District of Columbia, or Puerto Rico;

(B) with respect to which the Secretary has not approved a State plan amendment submitted under subsection (a)(2); and

(C) that is not operating, on an ongoing basis, an asset verification program in accordance with this section.

(Aug. 14, 1935, ch. 531, title XIX, §1940, as added Pub. L. 110–252, title VII, §7001(d)(1), June 30, 2008, 122 Stat. 2391; amended Pub. L. 116–3, §4, Jan. 24, 2019, 133 Stat. 7; Pub. L. 117–328, div. FF, title V, §5101(c), Dec. 29, 2022, 136 Stat. 5935.)

Editorial Notes

REFERENCES IN TEXT

The Right to Financial Privacy Act, referred to in subsecs. (b) to (d), probably means the Right to Financial Privacy Act of 1978, title XI of Pub. L. 95–630, Nov.

10, 1978, 92 Stat. 3697, which is classified generally to chapter 35 (§ 3401 et seq.) of Title 12, Banks and Banking. For complete classification of this Act to the Code, see Short Title note set out under section 3401 of Title 12 and Tables.

AMENDMENTS

2022—Subsec. (a)(3)(A)(iii). Pub. L. 117–328, § 5101(c)(1)(A), added cl. (iii).

Subsec. (a)(4). Pub. L. 117–328, § 5101(c)(1)(B), substituted ''Exemption of certain territories'' for ''Exemption of territories'' in heading and '', the District of Columbia, and Puerto Rico'' for ''and the District of Columbia'' in text.

Subsec. (k)(1). Pub. L. 117–328, § 5101(c)(2)(A), in introductory provisions, struck out ''beginning on or after January 1, 2021'' after ''With respect to a calendar quarter''; substituted ''for—'' and subpar. (A) for ''for a noncompliant State shall be reduced—''; redesignated former subpars. (A) to (D) as cls. (i) to (iv), respectively, of subpar. (A) and realigned margins; and added subpar. (B).

Subsec. (k)(2)(A). Pub. L. 117–328, § 5101(c)(2)(B), substituted '', the District of Columbia, or Puerto Rico'' for ''or the District of Columbia''.

2019—Subsec. (k). Pub. L. 116–3 added subsec. (k).

§ 1396w–1. Medicaid Improvement Fund

(a) Establishment

The Secretary shall establish under this subchapter a Medicaid Improvement Fund (in this section referred to as the ''Fund'') which shall be available to the Secretary to improve the management of the Medicaid program by the Centers for Medicare & Medicaid Services, including oversight of contracts and contractors and evaluation of demonstration projects, and, in accordance with subsection (b)(3), for the purposes of subparagraph (B) of such subsection. Payments made for activities under this subsection shall be in addition to payments that would otherwise be made for such activities.

(b) Funding

(1) In general

There shall be available to the Fund, for expenditures from the Fund for fiscal year 2023 and thereafter, $0.

(2) Funding limitation

Amounts in the Fund pursuant to paragraph (1) shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). Amounts in the Fund pursuant to paragraph (3) shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under such paragraph (3). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentences.

(3) Additional funding for State activities relating to mechanized claims systems

(A) In general

In addition to the amount made available under paragraph (1), there shall be available to the Fund, for expenditures from the Fund in accordance with subparagraph (B), for fiscal year 2028 and thereafter, $0, to remain available until expended.

(B) Purposes

The Secretary shall use amounts made available to the Fund under subparagraph (A) to pay to each State which has a plan approved under this subchapter, for each quarter beginning during or after fiscal year 2025 an amount equal to—

(i) 100 percent minus the percent specified in clause (i) of section 1396b(a)(3)(A) of this title of so much of the sums expended by the State during such quarter as are attributable to the activities described in such clause;

(ii) 100 percent minus the Federal medical assistance percentage applied under clause (iii) of such section of so much of the sums expended during such quarter (as found necessary by the Secretary under such clause) by the State as are attributable to the activities described in such clause; and

(iii) 100 percent minus the percent specified in section 1396b(a)(3)(B) of this title of so much of the sums expended by the State during such quarter as are attributable to the activities described in such section.

(Aug. 14, 1935, ch. 531, title XIX, § 1941, as added Pub. L. 110–252, title VII, § 7002(b), June 30, 2008, 122 Stat. 2395; amended Pub. L. 111–8, div. F, title II, § 226, Mar. 11, 2009, 123 Stat. 784; Pub. L. 111–127, § 4, Jan. 27, 2010, 124 Stat. 5; Pub. L. 111–148, title II, § 2007(b), Mar. 23, 2010, 124 Stat. 285; Pub. L. 114–198, title VII, § 707, July 22, 2016, 130 Stat. 754; Pub. L. 115–120, div. C, § 3006, Jan. 22, 2018, 132 Stat. 37; Pub. L. 115–123, div. E, title XII, § 53105, Feb. 9, 2018, 132 Stat. 302; Pub. L. 115–271, title V, § 5061, Oct. 24, 2018, 132 Stat. 3976; Pub. L. 116–3, § 5, Jan. 24, 2019, 133 Stat. 8; Pub. L. 116–29, § 2, July 5, 2019, 133 Stat. 1031; Pub. L. 116–59, div. B, title VI, § 1604, Sept. 27, 2019, 133 Stat. 1108; Pub. L. 116–69, div. B, title VI, § 1602, Nov. 21, 2019, 133 Stat. 1139; Pub. L. 116–159, div. C, title VI, § 2602, Oct. 1, 2020, 134 Stat. 738; Pub. L. 116–215, div. B, title III, § 1303, Dec. 11, 2020, 134 Stat. 1046; Pub. L. 116–260, div. CC, title IV, § 406, Dec. 27, 2020, 134 Stat. 3003; Pub. L. 117–328, div. FF, title V, § 5141, Dec. 29, 2022, 136 Stat. 5953; Pub. L. 118–15, div. B, title III, § 2342, Sept. 30, 2023, 137 Stat. 96; Pub. L. 118–22, div. B, title II, § 302, Nov. 17, 2023, 137 Stat. 121; Pub. L. 118–35, div. B, title I, § 122, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, § 212, Mar. 9, 2024, 138 Stat. 414.)

Editorial Notes

AMENDMENTS

2024—Subsec. (b)(3)(A). Pub. L. 118–42 substituted ''$0'' for ''$5,140,428,729''.

Pub. L. 118–35 substituted ''$5,140,428,729'' for ''$5,796,117,810''.

2023—Subsec. (b)(3)(A). Pub. L. 118–22 substituted ''$5,796,117,810'' for ''$6,357,117,810''.

Pub. L. 118–15 substituted ''$6,357,117,810'' for ''$7,000,000,000''.

2022—Subsec. (b)(3)(A). Pub. L. 117–328 substituted ''for fiscal year 2028 and thereafter, $7,000,000,000'' for ''for fiscal year 2025 and thereafter, $0''.

2020—Subsec. (b)(1). Pub. L. 116–159, § 2602(1), substituted ''2023'' for ''2021''.

Subsec. (b)(3)(A). Pub. L. 116–260 substituted ''$0'' for ''$3,464,000,000''.

Pub. L. 116–215 substituted ''$3,464,000,000'' for ''$3,446,000,000''.

Pub. L. 116–159, § 2602(2), substituted ''$3,446,000,000'' for ''$1,960,000,000''.

2019—Subsec. (b)(1). Pub. L. 116–59, § 1604(1), substituted ''$0'' for ''$1,000,000''.

Pub. L. 116–29 substituted ''$1,000,000'' for ''$6,000,000''.

Pub. L. 116–3 substituted ''$6,000,000'' for ''$31,000,000''.

Subsec. (b)(3). Pub. L. 116–59, § 1604(2)(A), substituted ''2025'' for ''2023'' in subpars. (A) and (B).

Subsec. (b)(3)(A). Pub. L. 116–69 substituted ''$1,960,000,000'' for ''$2,387,000,000''.

Pub. L. 116–59, § 1604(2)(B), substituted ''$2,387,000,000'' for ''$0''.

2018—Subsec. (a). Pub. L. 115–120, § 3006(1), inserted before period at end of first sentence '', and, in accordance with subsection (b)(3), for the purposes of subparagraph (B) of such subsection''.

Subsec. (b)(1). Pub. L. 115–271 substituted ''$31,000,000'' for ''$0''.

Pub. L. 115–123, § 53105(1), substituted ''$0'' for ''$5,000,000''.

Subsec. (b)(2). Pub. L. 115–120, § 3006(2)(A), inserted ''pursuant to paragraph (1)'' after ''in the Fund'' in first sentence and ''Amounts in the Fund pursuant to paragraph (3) shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under such paragraph (3).'' after first sentence and substituted ''the previous sentences'' for ''the previous sentence'' in last sentence.

Subsec. (b)(3). Pub. L. 115–120, § 3006(2)(B), added par. (3).

Subsec. (b)(3)(A). Pub. L. 115–123, § 53105(2), substituted ''$0'' for ''$980,000,000''.

2016—Subsec. (b)(1). Pub. L. 114–198 amended par. (1) generally. Prior to amendment, text read as follows: ''There shall be available to the Fund, for expenditures from the Fund—

''(A) for fiscal year 2014, $0; and

''(B) for each of fiscal years 2015 through 2018, $0.''

2010—Subsec. (b)(1)(A). Pub. L. 111–148, § 2007(b)(1), which directed substitution of ''$0'' for ''$100,000,000'', was executed by making the substitution for ''$10,000,000'', to reflect the probable intent of Congress and intervening amendment by Pub. L. 111–127. See below.

Pub. L. 111–127 substituted ''$10,000,000'' for ''$100,000,000''.

Subsec. (b)(1)(B). Pub. L. 111–148, § 2007(b)(2), substituted ''$0'' for ''$150,000,000''.

2009—Subsec. (b)(1)(B). Pub. L. 111–8 inserted ''each of'' after ''for''.

§ 1396w–2. Authorization to receive relevant information

(a) In general

Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant to eligibility determinations under this subchapter (including eligibility files maintained by Express Lane agencies described in section 1396a(e)(13)(F) of this title, information described in paragraph (2) or (3) of section 1320b–7(a) of this title, vital records information about births in any State, and information described in sections 653(i) and 1396a(a)(25)(I) of this title) is authorized to convey such data or information to the State agency administering the State plan under this subchapter, to the extent such conveyance meets the requirements of subsection (b).

(b) Requirements for conveyance

Data or information may be conveyed pursuant to subsection (a) only if the following requirements are met:

(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

(2) Such data or information are used solely for the purposes of—

(A) identifying individuals who are eligible or potentially eligible for medical assistance under this subchapter and enrolling or attempting to enroll such individuals in the State plan; and

(B) verifying the eligibility of individuals for medical assistance under the State plan.

(3) An interagency or other agreement, consistent with standards developed by the Secretary—

(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

(c) Penalties for improper disclosure

(1) Civil money penalty

A private entity described in the[1] subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section is subject to a civil money penalty in an amount equal to $10,000 for each such unauthorized publication or disclosure. The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(2) Criminal penalty

A private entity described in the[1] subsection (a) that willfully publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section shall be fined not more than $10,000 or imprisoned not more than 1 year, or both, for each such unauthorized publication or disclosure.

(d) Rule of construction

The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).

(Aug. 14, 1935, ch. 531, title XIX, § 1942, as added Pub. L. 111–3, title II, § 203(d)(1), Feb. 4, 2009, 123 Stat. 47.)

[1] So in original.

Statutory Notes and Related Subsidiaries

AUTHORIZATION FOR STATES ELECTING EXPRESS LANE OPTION TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE

Pub. L. 111–3, title II, § 203(e), Feb. 4, 2009, 123 Stat. 49, provided that: ''The Secretary shall enter into such agreements as are necessary to permit a State that elects the Express Lane option under section 1902(e)(13) of the Social Security Act [42 U.S.C. 1396a(e)(13)] to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under a State child health plan under CHIP or a State plan under Medicaid from the following:

''(1) The National Directory of New Hires established under section 453(i) of the Social Security Act (42 U.S.C. 653(i)).

''(2) Data regarding enrollment in insurance that may help to facilitate outreach and enrollment under the State Medicaid plan, the State CHIP plan, and such other programs as the Secretary may specify.''

[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.]

§ 1396w–3. Enrollment simplification and coordination with State health insurance exchanges

(a) Condition for participation in Medicaid

As a condition of the State plan under this subchapter and receipt of any Federal financial assistance under section 1396b(a) of this title for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is[1] met.

(b) Enrollment simplification and coordination with State health insurance exchanges and CHIP

(1) In general

A State shall establish procedures for—

(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 18031 of this title as being eligible for—

(i) medical assistance under the State plan or under a waiver of the plan; or

(ii) child health assistance under the State child health plan under subchapter XXI;

(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under subchapter XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 18071 of this title, and any other assistance or subsidies available for coverage obtained through the Exchange;

(D) ensuring that the State agency responsible for administering the State plan under this subchapter (in this section referred to as the ''State Medicaid agency''), the State agency responsible for administering the State child health plan under subchapter XXI (in this section referred to as the ''State CHIP agency'') and an Exchange established by the State under section 18031 of this title utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this subchapter, subchapter XXI, or a qualified health plan, as appropriate;

(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under subchapter XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with the requirements of section 1396a(a)(43) of this title; and

(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this subchapter or for child health assistance under subchapter XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(2) Agreements with State health insurance exchanges

The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 18031 of this title under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986

[1] So in original. Probably should be ''are''.

(and, if applicable, advance payment of such assistance under section 18082 of this title), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

(3) Streamlined enrollment system

The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 18083 of this title (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

(4) Enrollment website requirements

The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 18031 of this title and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

(5) Continued need for assessment for home and community-based services

Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).[2]

(Aug. 14, 1935, ch. 531, title XIX, § 1943, as added Pub. L. 111–148, title II, § 2201, Mar. 23, 2010, 124 Stat. 289.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(C), (2), (4), is classified generally to Title 26, Internal Revenue Code.

§ 1396w–3a. Requirements relating to qualified prescription drug monitoring programs and prescribing certain controlled substances

(a) In general

Subject to subsection (d), beginning October 1, 2021, a State—

(1) shall require each covered provider to check, in accordance with such timing, manner, and form as specified by the State, the prescription drug history of a covered individual being treated by the covered provider through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance; and

(2) in the case that such a provider is not able to conduct such a check despite a good faith effort by such provider—

(A) shall require the provider to document such good faith effort, including the reasons why the provider was not able to conduct the check; and

(B) may require the provider to submit, upon request, such documentation to the State.

(b) Qualified prescription drug monitoring program described

A qualified prescription drug monitoring program described in this subsection is, with respect to a State, a prescription drug monitoring program administered by the State that, at a minimum, satisfies each of the following criteria:

(1) The program facilitates access by a covered provider to, at a minimum, the following information with respect to a covered individual, in as close to real-time as possible:

(A) Information regarding the prescription drug history of a covered individual with respect to controlled substances.

(B) The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period.

(C) The name, location, and contact information (or other identifying number selected by the State, such as a national provider identifier issued by the National Plan and Provider Enumeration System of the Centers for Medicare & Medicaid Services) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period.

(2) The program facilitates the integration of information described in paragraph (1) into the workflow of a covered provider, which may include the electronic system the covered provider uses to prescribe controlled substances.

A qualified prescription drug monitoring program described in this subsection, with respect to a State, may have in place, in accordance with applicable State and Federal law, a data-sharing agreement with the State Medicaid program that allows the medical director and pharmacy director of such program (and any designee of such a director who reports directly to such director) to access the information described in paragraph (1) in an electronic format. The State Medicaid program under this subchapter may facilitate reasonable and limited access, as determined by the State and ensuring documented beneficiary protections regarding the use of such data, to such qualified prescription drug monitoring program for the medical

[2] Probably means subsection (a)(10)(A)(ii)(VI) of section 1396a of this title.

director or pharmacy director of any managed care entity (as defined under section 1396u–2(a)(1)(B) of this title) that has a contract with the State under section 1396b(m) of this title or under section 1396d(t)(3) of this title, or the medical director or pharmacy director of any entity that has a contract to manage the pharmaceutical benefit with respect to individuals enrolled in the State plan (or under a waiver of the State plan). All applicable State and Federal security and privacy laws shall apply to the directors or designees of such directors of any State Medicaid program or entity accessing a qualified prescription drug monitoring program under this section.

(c) Application of privacy rules clarification

The Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subsection (b) in the same manner as the Secretary is required under subparagraph (J) of section 1395w–104(c)(5) of this title to clarify privacy requirements related to the sharing of data described in such subparagraph.

(d) Ensuring access

In order to ensure reasonable access to health care, the Secretary shall waive the application of the requirement under subsection (a), with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1395w–104(c)(5)(D)(ii)(II) of this title).

(e) Reports

(1) State reports

Each State shall include in the annual report submitted to the Secretary under section 1396r–8(g)(3)(D) of this title, beginning with such reports submitted for 2023, information including, at a minimum, the following information for the most recent 12-month period:

(A) The percentage of covered providers (as determined pursuant to a process established by the State) who checked the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

(B) Aggregate trends with respect to prescribing controlled substances such as—

(i) the quantity of daily morphine milligram equivalents prescribed for controlled substances;

(ii) the number and quantity of daily morphine milligram equivalents prescribed for controlled substances per covered individual; and

(iii) the types of controlled substances prescribed, including the dates of such prescriptions, the supplies authorized (including the duration of such supplies), and the period of validity of such prescriptions, in different populations (such as individuals who are elderly, individuals with disabilities, and individuals who are enrolled under both this subchapter and subchapter XVIII).

(C) Whether or not the State requires (and a detailed explanation as to why the State does or does not require) pharmacists to check the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before dispensing a controlled substance to such individual.

(D) An accounting of any data or privacy breach of a qualified prescription drug monitoring program described in subsection (b), the number of covered individuals impacted by each such breach, and a description of the steps the State has taken to address each such breach, including, to the extent required by State or Federal law or otherwise determined appropriate by the State, alerting any such impacted individual and law enforcement of the breach.

(2) Report by CMS

Not later than October 1, 2023, the Administrator of the Centers for Medicare & Medicaid Services shall publish on the publicly available website of the Centers for Medicare & Medicaid Services a report including the following information:

(A) Guidance for States on how States can increase the percentage of covered providers who use qualified prescription drug monitoring programs described in subsection (b).

(B) Best practices for how States and covered providers should use such qualified prescription drug monitoring programs to reduce the occurrence of abuse of controlled substances.

(f) Increase to FMAP and Federal matching rates for certain expenditures relating to qualified prescription drug monitoring programs

(1) In general

With respect to a State that meets the condition described in paragraph (2) and any quarter occurring during fiscal year 2019 or fiscal year 2020, the Federal medical assistance percentage or Federal matching rate that would otherwise apply to such State under section 1396b(a) of this title for such quarter, with respect to expenditures by the State for activities under the State plan (or a waiver of such plan) to design, develop, or implement a prescription drug monitoring program (and to make connections to such program) that satisfies the criteria described in paragraphs (1) and (2) of subsection (b), shall be equal to 100 percent.

(2) Condition

The condition described in this paragraph, with respect to a State, is that the State (in this paragraph referred to as the ''administering State'') has in place agreements with all States that are contiguous to such administering State that, when combined, enable covered providers in all such contiguous States to access, through the prescription drug monitoring program, the information that is described in subsection (b)(1) of covered individuals of such administering State and

that covered providers in such administering State are able to access through such program.

(g) Rule of construction

Nothing in this section prevents a State from requiring pharmacists to check the prescription drug history of covered individuals through a qualified prescription drug monitoring program before dispensing controlled substances to such individuals.

(h) Definitions

In this section:

(1) Controlled substance

The term ''controlled substance'' means a drug that is included in schedule II of section 812(c) of title 21 and, at the option of the State involved, a drug included in schedule III or IV of such section.

(2) Covered individual

The term ''covered individual'' means, with respect to a State, an individual who is enrolled in the State plan (or under a waiver of such plan). Such term does not include an individual who—

(A) is receiving—

(i) hospice or palliative care; or

(ii) treatment for cancer;

(B) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(C) the State elects to treat as exempted from such term.

(3) Covered provider

(A) In general

The term ''covered provider'' means, subject to subparagraph (B), with respect to a State, a health care provider who is participating under the State plan (or waiver of the State plan) and licensed, registered, or otherwise permitted by the State to prescribe a controlled substance (or the designee of such provider).

(B) Exceptions

(i) In general

Beginning October 1, 2021, for purposes of this section, such term does not include a health care provider included in any type of health care provider determined by the Secretary to be exempt from application of this section under clause (ii).

(ii) Exceptions process

Not later than October 1, 2020, the Secretary, after consultation with the National Association of Medicaid Directors, national health care provider associations, Medicaid beneficiary advocates, and advocates for individuals with rare diseases, shall determine, based on such consultations, the types of health care providers (if any) that should be exempted from the definition of the term ''covered provider'' for purposes of this section.

(Aug. 14, 1935, ch. 531, title XIX, § 1944, as added Pub. L. 115–271, title V, § 5042(a), Oct. 24, 2018, 132 Stat. 3967.)

Editorial Notes

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c), is section 264(c) of Pub. L. 104–191, title II, Aug. 21, 1996, 110 Stat. 2033, which is set out as a note under section 1320d–2 of this title.

Statutory Notes and Related Subsidiaries

GUIDANCE

Pub. L. 115–271, title V, § 5042(b), Oct. 24, 2018, 132 Stat. 3970, provided that: ''Not later than October 1, 2019, the Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall issue guidance on best practices on the uses of prescription drug monitoring programs required of prescribers and on protecting the privacy of Medicaid beneficiary information maintained in and accessed through prescription drug monitoring programs.''

DEVELOPMENT OF MODEL STATE PRACTICES

Pub. L. 115–271, title V, § 5042(c), Oct. 24, 2018, 132 Stat. 3970, provided that:

''(1) IN GENERAL.—Not later than October 1, 2020, the Secretary of Health and Human Services shall develop and publish model practices to assist State Medicaid program operations in identifying and implementing strategies to utilize data-sharing agreements described in the matter following paragraph (2) of section 1944(b) of the Social Security Act [42 U.S.C. 1396w–3a(b)], as added by subsection (a), for the following purposes:

''(A) Monitoring and preventing fraud, waste, and abuse.

''(B) Improving health care for individuals enrolled in a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or under a waiver of such plan) who—

''(i) transition in and out of coverage under such title;

''(ii) may have sources of health care coverage in addition to coverage under such title; or

''(iii) pay for prescription drugs with cash.

''(C) Any other purposes specified by the Secretary.

''(2) ELEMENTS OF MODEL PRACTICES.—The model practices described in paragraph (1)—

''(A) shall include strategies for assisting States in allowing the medical director or pharmacy director (or designees of such a director) of managed care organizations or pharmaceutical benefit managers to access information with respect to all covered individuals served by such managed care organizations or pharmaceutical benefit managers to access as a single data set, in an electronic format; and

''(B) shall include any appropriate beneficiary protections and privacy guidelines.

''(3) CONSULTATION.—In developing model practices under this subsection, the Secretary shall consult with the National Association of Medicaid Directors, managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act [42 U.S.C. 1396u–2(a)(1)(B)]) with contracts with States pursuant to section 1903(m) of such Act [42 U.S.C. 1396b(m)], pharmaceutical benefit managers, physicians and other health care providers, beneficiary advocates, and individuals with expertise in health care technology related to prescription drug monitoring programs and electronic health records.''

§ 1396w–4. State option to provide coordinated care through a health home for individuals with chronic conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section

1396a(a)(10)(B) of this title (relating to comparability), and any other provision of this subchapter for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

(c) Payments

(1) In general

A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1396b(a) of this title, except that, subject to paragraph (4), during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

(2) Methodology

(A) In general

The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1396a(a)(30)(A) of this title.

(B) Alternate models of payment

The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) Planning grants

(A) In general

Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) State contribution

A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1396d(b) of this title (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

(C) Limitation

The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

(4) Special rule relating to substance use disorder health homes

(A) In general

In the case of a State with an SUD-focused State plan amendment approved by the Secretary on or after October 1, 2018, the Secretary may, at the request of the State, extend the application of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-eligible individuals under such State plan amendment, in addition to the first 8 fiscal year quarters the State plan amendment is in effect, for the subsequent 2 fiscal year quarters that the State plan amendment is in effect. Nothing in this section shall be construed as prohibiting a State with a State plan amendment that is approved under this section and that is not an SUD-focused State plan amendment from additionally having approved on or after such date an SUD-focused State plan amendment under this section, including for purposes of application of this paragraph.

(B) Report requirements

In the case of a State with an SUD-focused State plan amendment for which the application of the Federal medical assistance percentage has been extended under subparagraph (A), such State shall, at the end of the period of such State plan amendment, submit to the Secretary a report on the following, with respect to SUD-eligible individuals provided health home services under such State plan amendment:

(i) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.

(ii) The access of such individuals to health care.

(iii) The total expenditures of such individuals for health care.

For purposes of this subparagraph, the Secretary shall specify all applicable measures for determining quality, access, and expenditures.

(C) Best practices

Not later than October 1, 2020, the Secretary shall make publicly available on the

internet website of the Centers for Medicare & Medicaid Services best practices for designing and implementing an SUD-focused State plan amendment, based on the experiences of States that have State plan amendments approved under this section that include SUD-eligible individuals.

(D) Definitions

For purposes of this paragraph:

(i) SUD-eligible individuals

The term ''SUD-eligible individual'' means, with respect to a State, an individual who satisfies all of the following:

(I) The individual is an eligible individual with chronic conditions.

(II) The individual is an individual with a substance use disorder.

(III) The individual has not previously received health home services under any other State plan amendment approved for the State under this section by the Secretary.

(ii) SUD-focused State plan amendment

The term ''SUD-focused State plan amendment'' means a State plan amendment under this section that is designed to provide health home services primarily to SUD-eligible individuals.

(d) Hospital referrals

A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

(e) Coordination

A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(f) Monitoring

A State shall include in the State plan amendment—

(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

(g) Report on quality measures

As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

(h) Definitions

In this section:

(1) Eligible individual with chronic conditions

(A) In general

Subject to subparagraph (B), the term ''eligible individual with chronic conditions'' means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

(B) Rule of construction

Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) Chronic condition

The term ''chronic condition'' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

(3) Health home

The term ''health home'' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

(4) Health home services

(A) In general

The term ''health home services'' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) Services described

The services described in this subparagraph are—

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated provider

The term ''designated provider'' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

(A) has the systems and infrastructure in place to provide health home services; and

(B) satisfies the qualification standards established by the Secretary under subsection (b).

(6) Team of health care professionals

The term ''team of health care professionals'' means a team of health professionals (as described in the State plan amendment) that may—

(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) Health team

The term ''health team'' has the meaning given such term for purposes of section 256a–1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1945, as added Pub. L. 111–148, title II, § 2703(a), Mar. 23, 2010, 124 Stat. 319; amended Pub. L. 115–271, title I, § 1006(a), Oct. 24, 2018, 132 Stat. 3913.)

Editorial Notes

REFERENCES IN TEXT

Section 5001 of Public Law 111–5, referred to in subsec. (c)(3)(B), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under section 1396d of this title.

AMENDMENTS

2018—Subsec. (c)(1). Pub. L. 115–271, § 1006(a)(1), inserted ''subject to paragraph (4),'' after ''except that,''.

Subsec. (c)(4). Pub. L. 115–271, § 1006(a)(2), added par. (4).

Statutory Notes and Related Subsidiaries

SURVEY AND INTERIM REPORT

Pub. L. 111–148, title II, § 2703(b)(2), Mar. 23, 2010, 124 Stat. 322, provided that:

''(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act [42 U.S.C. 1396w–4] (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

''(i) hospital admission rates;

''(ii) chronic disease management;

''(iii) coordination of care for individuals with chronic conditions;

''(iv) assessment of program implementation;

''(v) processes and lessons learned (as described in subparagraph (B));

''(vi) assessment of quality improvements and clinical outcomes under such option; and

''(vii) estimates of cost savings.

''(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.''

§ 1396w–4a. State option to provide coordinated care through a health home for children with medically complex conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), beginning October 1, 2022, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to children with medically complex conditions who choose to enroll in a health home under this section by selecting a designated provider, a team of health care professionals operating with such a provider, or a health team as the child's health home for purposes of providing the child with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a health home for purposes of this section. Such standards shall include requiring designated providers, teams of health care professionals operating with such providers, and health teams to demonstrate to the State the ability to do the following:

(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times.

(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences.

(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care.

(4) Coordinate access to—

(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

(B) palliative services if the State provides such services under the State plan (or a waiver of such plan).

(5) Coordinate care for children with medically complex conditions with out-of-State providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under subsection (e)(1) and section 431.52 of title 42, Code of Federal Regulations.

(6) Collect and report information under subsection (g)(1).

(c) Payments

(1) In general

A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each child with medically complex conditions that selects such provider, team of health care professionals, or health team as the child's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1396b(a) of this title, except that, during the first 2 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be increased by 15 percentage points, but in no case may exceed 90 percent.

(2) Methodology

(A) In general

The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each child with medically complex conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, the severity or number of each such child's chronic conditions, life-threatening illnesses, disabilities, or rare diseases, or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1396a(a)(30)(A) of this title.

(B) Alternate models of payment

The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) Planning grants

(A) In general

Beginning October 1, 2022, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) State contribution

A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1396d(b) of this title (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

(C) Limitation

The total amount of payments made to States under this paragraph shall not exceed $5,000,000.

(d) Coordinating care

(1) Hospital notification

A State with a State plan amendment approved under this section shall require each hospital that is a participating provider under the State plan (or a waiver of such plan) to establish procedures for, in the case of a child with medically complex conditions who is enrolled in a health home pursuant to this section and seeks treatment in the emergency department of such hospital, notifying the health home of such child of such treatment.

(2) Education with respect to availability of health home services

In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for educating providers participating in the State plan (or a waiver of such plan) on the availability of health home services for children with medically complex conditions, including the process by which such providers can refer such children to a designated provider, team of health care professionals operating such[1] a provider, or health team for the purpose of establishing a health home through which such children may receive such services.

(3) Family education

In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for educating families with children eligible to receive health home services pursuant to this section of the availability of such services. Such process shall include the participation of family-to-family entities or other public or private organizations or entities who provide outreach and information on the availability of health care items and services to families of individuals eligible to receive medical assistance under the State plan (or a waiver of such plan).

(4) Mental health coordination

A State with a State plan amendment approved under this section shall consult and coordinate, as appropriate, with the Secretary in addressing issues regarding the prevention and treatment of mental illness and substance use among children with medically complex conditions receiving health home services under this section.

(e) Guidance on coordinating care from out-of-State providers

(1) In general

Not later than October 1, 2020, the Secretary shall issue (and update as the Secretary deter-

[1] So in original. Probably should be preceded by ''with''.

mines necessary) guidance to State Medicaid directors on—

(A) best practices for using out-of-State providers to provide care to children with medically complex conditions;

(B) coordinating care for such children provided by such out-of-State providers (including when provided in emergency and non-emergency situations);

(C) reducing barriers for such children receiving care from such providers in a timely fashion; and

(D) processes for screening and enrolling such providers in the respective State plan (or a waiver of such plan), including efforts to streamline such processes or reduce the burden of such processes on such providers.

(2) Stakeholder input

In carrying out paragraph (1), the Secretary shall issue a request for information to seek input from children with medically complex conditions and their families, States, providers (including children's hospitals, hospitals, pediatricians, and other providers), managed care plans, children's health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care for such children provided by out-of-State providers.

(f) Monitoring

A State shall include in the State plan amendment—

(1) a methodology for tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management under this section;

(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider); and

(3) a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-State providers.

(g) Data collection

(1) Provider reporting requirements

In order to receive payments from a State under subsection (c), a designated provider, a team of health care professionals operating with such a provider, or a health team shall report to the State, at such time and in such form and manner as may be required by the State, the following information:

(A) With respect to each such provider, team of health care professionals, or health team, the name, National Provider Identification number, address, and specific health care services offered to be provided to children with medically complex conditions who have selected such provider, team of health care professionals, or health team as the health home of such children.

(B) Information on all applicable measures for determining the quality of health home services provided by such provider, team of health care professionals, or health team, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under this subchapter, subchapter XXI, and section 1320b–9a of this title.

(C) Such other information as the Secretary shall specify in guidance.

When appropriate and feasible, such provider, team of health care professionals, or health team, as the case may be, shall use health information technology in providing the State with such information.

(2) State reporting requirements

(A) Comprehensive report

A State with a State plan amendment approved under this section shall report to the Secretary (and, upon request, to the Medicaid and CHIP Payment and Access Commission), at such time and in such form and manner determined by the Secretary to be reasonable and minimally burdensome, the following information:

(i) Information reported under paragraph (1).

(ii) The number of children with medically complex conditions who have selected a health home pursuant to this section.

(iii) The nature, number, and prevalence of chronic conditions, life-threatening illnesses, disabilities, or rare diseases that such children have.

(iv) The type of delivery systems and payment models used to provide services to such children under this section.

(v) The number and characteristics of designated providers, teams of health care professionals operating with such providers, and health teams selected as health homes pursuant to this section, including the number and characteristics of out-of-State providers, teams of health care professionals operating with such providers, and health teams who have provided health care items and services to such children.

(vi) The extent to which such children receive health care items and services under the State plan.

(vii) Quality measures developed specifically with respect to health care items and services provided to children with medically complex conditions.

(B) Report on best practices

Not later than 90 days after a State has a State plan amendment approved under this section, such State shall submit to the Secretary, and make publicly available on the appropriate State website, a report on how the State is implementing guidance issued under subsection (e)(1), including through any best practices adopted by the State.

(h) Rule of construction

Nothing in this section may be construed—

(1) to require a child with medically complex conditions to enroll in a health home under this section;

(2) to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards established under subsection (b) as the child's health home; or

(3) to reduce or otherwise modify—

(A) the entitlement of children with medically complex conditions to early and periodic screening, diagnostic, and treatment services (as defined in section 1396d(r) of this title); or

(B) the informing, providing, arranging, and reporting requirements of a State under section 1396a(a)(43) of this title.

(i) Definitions

In this section:

(1) Child with medically complex conditions

(A) In general

Subject to subparagraph (B), the term ''child with medically complex conditions'' means an individual under 21 years of age who—

(i) is eligible for medical assistance under the State plan (or under a waiver of such plan); and

(ii) has at least—

(I) one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or

(II) one life-limiting illness or rare pediatric disease (as defined in section 360ff(a)(3) of title 21).

(B) Rule of construction

Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic, life threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) Chronic condition

The term ''chronic condition'' means a serious, long-term physical, mental, or developmental disability or disease, including the following:

(A) Cerebral palsy.

(B) Cystic fibrosis.

(C) HIV/AIDS.

(D) Blood diseases, such as anemia or sickle cell disease.

(E) Muscular dystrophy.

(F) Spina bifida.

(G) Epilepsy.

(H) Severe autism spectrum disorder.

(I) Serious emotional disturbance or serious mental health illness.

(3) Health home

The term ''health home'' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by a child with medically complex conditions (or the family of such child) to provide health home services.

(4) Health home services

(A) In general

The term ''health home services'' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) Services described

The services described in this subparagraph shall include—

(i) comprehensive care management;

(ii) care coordination, health promotion, and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-State providers, as medically necessary;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referrals to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated provider

The term ''designated provider'' means a physician (including a pediatrician or a pediatric specialty or subspecialty provider), children's hospital, clinical practice or clinical group practice, prepaid inpatient health plan or prepaid ambulatory health plan (as defined by the Secretary), rural clinic, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the State and approved by the Secretary to be qualified to be a health home for children with medically complex conditions on the basis of documentation evidencing that the entity has the systems, expertise, and infrastructure in place to provide health home services. Such term may include providers who are employed by, or affiliated with, a children's hospital.

(6) Team of health care professionals

The term ''team of health care professionals'' means a team of health care professionals (as described in the State plan amendment under this section) that may—

(A) include—

(i) physicians and other professionals, such as pediatricians or pediatric specialty or subspecialty providers, nurse care coordinators, dietitians, nutritionists, social workers, behavioral health professionals, physical therapists, occupational therapists, speech pathologists, nurses, individuals with experience in medical supportive technologies, or any professionals determined to be appropriate by the State and approved by the Secretary;

(ii) an entity or individual who is designated to coordinate such a team; and

(iii) community health workers, translators, and other individuals with culturally-appropriate expertise; and

(B) be freestanding, virtual, or based at a children's hospital, hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary.

(7) Health team

The term ''health team'' has the meaning given such term for purposes of section 256a–1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1945A, as added Pub. L. 116–16, § 3, Apr. 18, 2019, 133 Stat. 853.)

Editorial Notes

REFERENCES IN TEXT

Section 5001 of Public Law 111–5, referred to in subsec. (c)(3)(B), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under section 1396d of this title.

§ 1396w–5. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter and subchapter XXI, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter and subchapter XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this subchapter or subchapter XXI.

(3) Improving program data under this subchapter and subchapter XXI on race, ethnicity, sex, primary language, and disability status.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after March 23, 2010, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this subchapter and subchapter XXI; and

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w–22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on such bases.

(2) Reports on data analyses

Not later than 4 years after March 23, 2010, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this subchapter and under subchapter XXI based on analyses of the data collected under subsection (c).

(c) Implementing effective approaches

Not later than 24 months after March 23, 2010, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.

(Aug. 14, 1935, ch. 531, title XIX, § 1946, as added Pub. L. 111–148, title IV, § 4302(b)(2), Mar. 23, 2010, 124 Stat. 581.)

§ 1396w–6. State option to provide qualifying community-based mobile crisis intervention services

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to Statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), section 1396a(a)(23)(A) of this title (relating to freedom of choice of providers), or section 1396a(a)(27) of this title (relating to provider agreements), a State may, during the 5-year period beginning on the first day of the first fiscal year quarter that begins on or after the date that is 1 year after March 11, 2021, provide medical assistance for qualifying community-based mobile crisis intervention services.

(b) Qualifying community-based mobile crisis intervention services defined

For purposes of this section, the term ''qualifying community-based mobile crisis intervention services'' means, with respect to a State, items and services for which medical assistance is available under the State plan under this subchapter or a waiver of such plan, that are—

(1) furnished to an individual otherwise eligible for medical assistance under the State plan (or waiver of such plan) who is—

(A) outside of a hospital or other facility setting; and

(B) experiencing a mental health or substance use disorder crisis;

(2) furnished by a multidisciplinary mobile crisis team—

(A) that includes at least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State through a State plan amendment (or waiver of such plan);

(B) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction;

(C) that is able to respond in a timely manner and, where appropriate, provide—

(i) screening and assessment;

(ii) stabilization and de-escalation; and

(iii) coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed;

(D) that maintains relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable); and

(E) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements; and

(3) available 24 hours per day, every day of the year.

(c) Payments

Notwithstanding section 1396d(b) or 1396d(ff) of this title and subject to subsections (y) and (z) of section 1396d of this title, during each of the first 12 fiscal quarters occurring during the period described in subsection (a) that a State meets the requirements described in subsection (d), the Federal medical assistance percentage applicable to amounts expended by the State for medical assistance for qualifying community-based mobile crisis intervention services furnished during such quarter shall be equal to 85 percent. In no case shall the application of the previous sentence result in the Federal medical assistance percentage applicable to amounts expended by a State for medical assistance for such qualifying community-based mobile crisis intervention services furnished during a quarter being less than the Federal medical assistance percentage that would apply to such amounts expended by the State for such services furnished during such quarter without application of the previous sentence.

(d) Requirements

The requirements described in this subsection are the following:

(1) The State demonstrates, to the satisfaction of the Secretary that it will be able to support the provision of qualifying community-based mobile crisis intervention services that meet the conditions specified in subsection (b).

(2) The State provides assurances satisfactory to the Secretary that—

(A) any additional Federal funds received by the State for qualifying community-based mobile crisis intervention services provided under this section that are attributable to the increased Federal medical assistance percentage under subection (c) will be used to supplement, and not supplant, the level of State funds expended for such services for the fiscal year preceding the first fiscal quarter occurring during the period described in subsection (a);

(B) if the State made qualifying community-based mobile crisis intervention services available in a region of the State in such fiscal year, the State will continue to make such services available in such region under this section during each month occurring during the period described in subsection (a) for which the Federal medical assistance percentage under subsection (c) is applicable with respect to the State.

(e) Funding for State planning grants

There is appropriated, out of any funds in the Treasury not otherwise appropriated, $15,000,000 to the Secretary for purposes of implementing, administering, and making planning grants to States as soon as practicable for purposes of developing a State plan amendment or section 1315, 1396n(b), or 1396n(c) of this title waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services under this section, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XIX, §1947, as added Pub. L. 117–2, title IX, §9813, Mar. 11, 2021, 135 Stat. 213.)

§ 1396w–7. Supporting access to a continuum of crisis response services under Medicaid and CHIP

(a) Guidance

Not later than July 1, 2025, the Secretary, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall issue guidance to States regarding Medicaid and CHIP that includes the following:

(1) Provides, in consultation with health care providers and stakeholders with expertise in mental health and substance use disorder crisis response services, recommendations for an effective continuum of crisis response services that—

(A) includes crisis call centers, including 988 crisis services hotlines, mobile crisis teams, crisis response services delivered in home, community, residential facility, and hospital settings, and coordination with follow-on mental health and substance use disorder services, such as intensive outpatient and partial hospitalization programs, as well as connections to social services and supports;

(B) promotes access to appropriate and timely mental health and substance use disorder crisis response services in the least restrictive setting appropriate to an individual's needs; and

(C) promotes culturally competent, trauma-informed care, and crisis de-escalation.

(2) Outlines the Federal authorities through which States may finance and enhance under Medicaid and CHIP the availability of crisis response services across each stage of the continuum of crisis response services.

(3) Addresses how States under Medicaid and CHIP may support the ongoing implementation of crisis call centers, including 988 crisis services hotlines, and how Medicaid administrative funding, including enhanced matching, and the Medicaid Information Technology Architecture 3.0 framework, may be used to establish or enhance regional or statewide crisis

call centers, including 988 crisis services hotlines, that coordinate in real time.

(4) Identifies how States under Medicaid and CHIP may support access to crisis response services that are responsive to the needs of children, youth, and families, including through CHIP health services initiatives, behavioral disorder-specific crisis response, trained peer support services, and establishing or enhancing crisis call centers that are youth-focused.

(5) Identifies policies and practices to meet the need for crisis response services with respect to differing patient populations, including urban, rural, and frontier communities, differing age groups, cultural and linguistic minorities, individuals with co-occurring mental health and substance use disorder conditions, and individuals with disabilities.

(6) Identifies policies and practices to promote evidence-based suicide risk screenings and assessments.

(7) Identifies strategies to facilitate timely provision of crisis response services, including how States can enable access to crisis response services without requiring a diagnosis, the use of presumptive eligibility at different stages of the continuum of crisis response services, the use of telehealth to deliver crisis response services, strategies to make crisis response services available 24/7 in medically underserved regions, and best practices used by States and health providers for maximizing capacity to deliver crisis response services, such as identifying and repurposing available beds, space, and staff for crisis response services.

(8) Describes best practices for coordinating Medicaid and CHIP funding with other payors and sources of Federal funding for mental health and substance use disorder crisis response services, and best practices for Medicaid and CHIP financing when the continuum of crisis response services serves individuals regardless of payor.

(9) Describes best practices for establishing effective connections with follow-on mental health and substance use disorder services, as well as with social services and supports.

(10) Describes best practices for coordinating and financing a continuum of crisis response services through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and fee-for-service delivery systems, including when States carve-out from delivery through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, or fee-for-service systems, mental health or substance use disorder benefits or a subset of such services.

(11) Identifies strategies and best practices for measuring and monitoring utilization of, and outcomes related to, crisis response services.

(b) Technical assistance center

(1) In general

Not later than July 1, 2025, the Secretary, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall establish a technical assistance center to help States under Medicaid and CHIP design, implement, or enhance a continuum of crisis response services for children, youth, and adults. Such technical assistance shall, at least in part, provide support to States in—

(A) leveraging the Federal authorities through which Medicaid and CHIP may finance mental health and substance use disorder crisis response services;

(B) coordinating Medicaid and CHIP funds with other sources of Federal funding for mental health and substance use disorder crisis response services; and

(C) after the guidance described in subsection (a) is issued, adopting the best practices and strategies identified in such guidance.

(2) Compendium of best practices

The Secretary shall develop and maintain a publicly available compendium of best practices for the successful operation under Medicaid and CHIP of a continuum of crisis response services. The Secretary annually shall review the information available through the compendium and shall update such information when appropriate.

(c) Funding

There is appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, to remain available until expended for purposes of carrying out subsections (a) and (b), $8,000,000.

(d) Definitions

In this section:

(1) Secretary

The term ''Secretary'' means the Secretary of Health and Human Services.

(2) State

The term ''State'' means each of the 50 States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(Pub. L. 117–328, div. FF, title V, § 5124, Dec. 29, 2022, 136 Stat. 5947.)

Editorial Notes

CODIFICATION

Section was enacted as part of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022 and also as part of the Consolidated Appropriations Act, 2023, and not as part of the Social Security Act which comprises this chapter.

§ 1396w–8. Collection and reporting of comprehensive data for specified populations

(a) Recurring analysis and publication of health care data related to treatment for substance use disorder or a mental health condition

(1) In general

The Secretary, on an annual basis, shall link, analyze, and publish on a publicly avail-

able website data reported by States through the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system) relating to substance use disorder and mental health services provided to individuals enrolled under a State plan under this subchapter or a State child health plan under subchapter XXI (or under a waiver of such plans) who have been diagnosed with a substance use disorder or mental health condition, including an analysis that is disaggregated by age. Such enrollee information shall be de-identified of any personally identifying information, shall adhere to privacy standards established by the Department of Health and Human Services, and shall be aggregated to protect the privacy of enrollees, as necessary.

(2) Requirements

The analysis required under paragraph (1) shall include, at a minimum, the following data for each State (including, to the extent available, for the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa):

(A) The number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) in each of the major enrollment categories (as defined in a public letter from the Medicaid and CHIP Payment and Access Commission to the Secretary) who have been diagnosed with—

(i) a substance use disorder;

(ii) a mental health condition; or

(iii) a co-occurring substance use disorder and mental health condition.

(B) With respect to individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who have received a diagnosis described in subparagraph (A), a list of the substance use disorder and mental health treatment services, including, to the extent such data are available, specific adult and pediatric services by each major type of service, such as counseling, intensive home-based services, intensive care coordination, crisis services tailored to children and youth, peer support services, family-to-family support, inpatient hospitalization, medication-assisted treatment, residential treatment, and other appropriate services as identified by the Secretary, for which beneficiaries in each State received at least 1 service under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans).

(C) With respect to each diagnosis described in subparagraph (A), the number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who have such diagnosis and received services for such diagnosis under such plan or waiver by each major type of treatment service listed under subparagraph (B) within each major setting type, such as outpatient, inpatient, residential, and other home-based and community-based settings.

(D) The number of services provided under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) per individual enrolled under such plan or waiver who has a diagnosis described in subparagraph (A) for each such diagnosis and each major type of treatment service listed under subparagraph (B).

(E) The number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) by major enrollment category, who have a diagnosis described in subparagraph (A) and received substance use disorder or mental health treatment through—

(i) a Medicaid managed care entity (as defined in section 1396u–2(a)(1)(B) of this title), including the number of such individuals who received such assistance through a prepaid inpatient health plan (as defined by the Secretary) or a prepaid ambulatory health plan (as defined by the Secretary);

(ii) a fee-for-service payment model; or

(iii) an alternative payment model, to the extent available.

(F) The number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who have a diagnosis described in subparagraph (A) and received services for a mental health condition or a substance use disorder in an outpatient or community-based or home-based setting after receiving mental health or substance use disorder services in an inpatient or residential setting, and the number of mental health or substance use disorder services received by such individuals in the outpatient or community-based or home-based setting.

(G) The number and percentage of inpatient admissions in which services for a mental health condition or substance use disorder were provided to an individual enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) that occurred within 30 days after discharge from a hospital or residential facility in which services for a mental health condition or substance use disorder previously were provided to such individual, disaggregated by each diagnosis described in subparagraph (A) and type of facility, to the extent such information is available.

(H) The number of emergency department visits by an individual enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who has a diagnosis described in subparagraph (A) within 7 days of such individual being discharged from an inpatient stay at a hospital during which services for a mental health condition or substance use disorder

were provided, or from a mental health facility, an independent psychiatric wing of an acute care hospital, an intermediate care facility for individuals with intellectual disabilities, or a residential treatment facility, disaggregated by each diagnosis described in subparagraph (A) and type of facility, to the extent such information is available.

(I) The number and percentage of individuals who are enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) and received an assessment for a mental health condition.

(J) The number and percentage of individuals who are enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) and received an assessment for a substance use disorder.

(K) The number of mental health services provided to individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who received an assessment described in subparagraph (I) in the 30 days post-assessment.

(L) The number of substance use disorder treatment services provided to individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who received an assessment described in subparagraph (J) in the 30 days post-assessment.

(M) Prescription National Drug Code codes, fill dates, and number of days supply of any covered outpatient drug (as defined in section 1396r–8(k)(2) of this title) that was dispensed to an individual enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) with an episode described in subparagraph (G) or (H) during any period that occurs after the individual's discharge date defined in subparagraph (G) or (H) (as applicable), and before the admission date applicable under subparagraph (G) or the date of the emergency department visit applicable under subparagraph (H) that were—

(i) to treat a mental health condition; or

(ii) to treat a substance use disorder.

(b) Publication

(1) In general

Not later than 18 months after March 9, 2024, the Secretary shall make publicly available the first analysis required by subsection (a).

(2) Annual updates

The Secretary shall issue an updated version of the analysis required under subsection (a) not later than January 1 of each calendar year.

(3) Use of T–MSIS data

The analysis required under subsection (a) and updates required under paragraph (4) shall—

(A) use data and definitions from the T–MSIS data set that is no more than 12 months old on the date that the analysis or update is published; and

(B) as appropriate, include a description with respect to each State of the quality and completeness of the data and caveats describing the limitations of the data reported to the Secretary by the State that is sufficient to communicate the appropriate uses for the information.

(4) Revised publication

Beginning not later than 3 years after March 9, 2024, the Secretary annually shall publish a revised publication of the analysis required by subsection (a) that allows for a research-ready and publicly accessible interface of the publication and is developed after consultation with stakeholders on the usability of the data contained in the publication.

(5) Making T–MSIS data on substance use disorders and mental health conditions available to researchers

(A) Requirement to publish system of records notice

(i) In general

Subject to subparagraph (B), the Secretary shall publish in the Federal Register a system of records notice for the data specified in clause (ii) for the Transformed Medicaid Statistical Information System, in accordance with section 552a(e)(4) of title 5. The notice shall outline policies that protect the security and privacy of the data that, at a minimum, meet the security and privacy policies of SORN 09-70-0541 for the Medicaid Statistical Information System.

(ii) Required data

The data covered by the systems of records notice required under clause (i) shall be sufficient for researchers and States to analyze the prevalence of conditions described in subsection (a)(2)(A) in the Medicaid and Children's Health Insurance Program beneficiary population and the treatment of such conditions under Medicaid across all States (including the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), forms of treatment, and treatment settings.

(iii) Initiation of data-sharing activities

Not later than January 1, 2025, the Secretary shall initiate the data-sharing activities outlined in the notice required under clause (i).

(B) Satisfaction of requirement through existing system of records notice

The Secretary shall not be required to publish a new system of records notice as required under subparagraph (A) if, not later than January 1, 2025, the Secretary determines that the system of records notice published by the Secretary in the Federal Register on February 6, 2019 (84 Fed. Reg. 2230), satisfies the requirements described in subparagraph (A).

(Aug. 14, 1935, ch. 531, title XIX, § 1948, as added Pub. L. 118–42, div. G, title I, § 202, Mar. 9, 2024, 138 Stat. 399.)

SUBCHAPTER XX—BLOCK GRANTS AND PROGRAMS FOR SOCIAL SERVICES AND ELDER JUSTICE

Editorial Notes

CODIFICATION

2018—Pub. L. 115–123, div. E, title VIII, § 50802(1), Feb. 9, 2018, 132 Stat. 269, substituted ''AND PROGRAMS'' for ''TO STATES'' in subchapter heading.

Pub. L. 111–148, title VI, § 6703(a)(1)(A), Mar. 23, 2010, 124 Stat. 782, inserted ''AND ELDER JUSTICE'' after ''SOCIAL SERVICES'' in subchapter heading.

Division A—Block Grants to States for Social Services

§ 1397. Purposes of division; authorization of appropriations

For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of—

(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this division.

(Aug. 14, 1935, ch. 531, title XX, § 2001, as added Pub. L. 97–35, title XXIII, § 2352(a), Aug. 13, 1981, 95 Stat. 867; amended Pub. L. 111–148, title VI, § 6703(d)(1), Mar. 23, 2010, 124 Stat. 803.)

Editorial Notes

PRIOR PROVISIONS

A prior section 1397, act Aug. 14, 1935, ch. 531, title XX, § 2001, as added Jan. 4, 1975, Pub. L. 93–647, § 2, 88 Stat. 2337; amended June 17, 1980, Pub. L. 96–272, title II, § 207(b), 94 Stat. 526, authorized appropriations to carry out former provisions of this subchapter, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

2010—Pub. L. 111–148, § 6703(d)(1)(B), which directed substitution of ''this division'' for ''this subchapter'' wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed to the concluding provisions of this section, which is in subtitle A of title XX of act Aug. 14, 1935, to reflect the probable intent of Congress.

Pub. L. 111–148, § 6703(d)(1)(A), substituted ''division'' for ''subchapter'' in section catchline.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 97–35, title XXIII, § 2354, Aug. 13, 1981, 95 Stat. 874, provided that: ''Except as otherwise explicitly provided, the provisions of this subtitle [subtitle C (§§ 2351–2355) of title XXIII of Pub. L. 97–35, see Short Title of 1981 Amendment note set out under section 1305 of this title] and the repeals and amendments made by this subtitle, shall become effective on October 1, 1981.''

STUDY OF STATE SOCIAL SERVICE PROGRAMS; REPORT TO CONGRESS

Pub. L. 97–35, title XXIII, § 2355, Aug. 13, 1981, 95 Stat. 874, required Secretary of Health and Human Services to conduct a study to identify criteria and mechanisms which may be useful for States in assessing effectiveness and efficiency of State social service programs carried out with funds made available under this subchapter, such study to include consideration of Federal incentive payments as an option in rewarding States having high performance social service programs, and to report results of such study to Congress within one year after Aug. 13, 1981.

§ 1397a. Payments to States

(a) Amount; covered services

(1) Each State shall be entitled to payment under this division for each fiscal year in an amount equal to its allotment for such fiscal year, to be used by such State for services directed at the goals set forth in section 1397 of this title, subject to the requirements of this division.

(2) For purposes of paragraph (1)—

(A) services which are directed at the goals set forth in section 1397 of this title include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and

(B) expenditures for such services may include expenditures for—

(i) administration (including planning and evaluation);

(ii) personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions); and

(iii) conferences or workshops, and training or retraining through grants to nonprofit organizations within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986 or to individuals with social