

“(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, to⁴ 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, to⁴ 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

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

³So in original. Probably should be followed by “and”.

⁴So in original. The word “to” probably should not appear.

¹See References in Text note below.

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 1396o 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 eligi-

bility 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 1395o(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 1395o(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 1396o(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 1396o(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 cancer⁵ (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 sub-

paragraph (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 1396o(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 section⁵ (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 1396o 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

⁶So 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 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o 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 1395l 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 1395l 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 med-

ical 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 sur-

vey 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

⁷So in original. Probably should be "Investigation."

⁸Probably 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(1)(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 owner-

ship 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 Or-

ganizations 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 para-

graph (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 organization¹⁰ 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

¹⁰So 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 ben-

efits 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)(4)(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 Act¹ (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 re-determination 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 para-

graph (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 multi-jurisdictional 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 a¹³ 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

¹³So 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 paragraph¹⁵ 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 VI¹ 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 con-

cerning 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 1395l(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(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 MBI (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 1396o(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 Agency¹⁸ (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 be¹⁹ 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 "1396o(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, non-disabled 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 waived 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 proce-

dures 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 section²⁰ 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 Octo-

ber 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.

(II) 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. L. 107–121, § 2(a), (b)(1), (2), Jan. 15, 2002, 115 Stat. 2384; Pub. L. 108–40, § 7(b), June 30, 2003, 117 Stat. 837; Pub. L. 108–89, title IV, § 401(a), Oct. 1, 2003, 117 Stat. 1134; Pub. L. 108–173, title I, § 103(a)(1), (f)(1), title II, § 236(b)(1), Dec. 8, 2003, 117 Stat. 2154, 2160, 2211; Pub. L. 108–265, title I, § 105(b), June 30, 2004, 118 Stat. 744; Pub. L. 108–448, § 1(a), Dec. 8, 2004, 118 Stat. 3467; Pub. L. 109–91, title I, § 101(a), Oct. 20, 2005, 119 Stat. 2091; Pub. L. 109–171, title VI, §§ 6032(a), 6034(b), 6035(a), (b), 6062(a), 6065(a), 6083(a), Feb. 8, 2006, 120 Stat. 73, 76, 78, 79, 96, 101, 120; Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(iv), Dec. 20, 2006, 120 Stat. 3000; Pub. L. 110–90, § 3(a), Sept. 29, 2007, 121 Stat. 984; Pub. L. 110–173, title II, § 203(a), Dec. 29, 2007, 121 Stat. 2513; Pub. L. 110–252, title VII, § 7001(d)(2), June 30, 2008, 122 Stat. 2394; Pub. L. 110–275, title I, § 111(a), July 15, 2008, 122 Stat. 2503; Pub. L. 111–3, title I, § 113(b)(1), title II, §§ 203(a)(1), (c), (d)(3), 211(a)(1)(A), (b)(3)(B), title V, § 501(d)(1), (e)(1), Feb. 4, 2009, 123 Stat. 34, 40, 47, 49, 54, 87; Pub. L. 111–5, div. B, title V, §§ 5004(a)(1), 5005(a), 5006(b)(1), (e)(2)(A), Feb. 17, 2009, 123 Stat. 503, 505, 506, 510; Pub. L. 111–148, title II, §§ 2001(a)(1), (2)(A), (4)(A), (5)(A), (B), (b), (d)(1), (e)(1), 2002(a), (b), 2004(a), 2202(a), 2301(b), 2303(a)(1)–(3), (b)(2)(A), 2402(d)(1), 2901(c), title III, § 3021(b), title IV, § 4302(b)(1)(A), title VI, §§ 6103(d)(2), 6401(b)(1), (3), 6411(a)(1), 6501–6503, 6505, title VIII, § 8002(a)(2), (b), title X, § 10201(a)(1), (2), (b), Mar. 23, 2010, 124 Stat. 271, 274, 275, 277–279, 282, 283, 291–294, 296, 303, 333, 394, 581, 710, 751, 753, 773, 776, 777, 846, 917, 918; Pub. L. 111–152, title I, §§ 1004(b)(1), (e), 1202(a)(1), Mar. 30, 2010, 124 Stat. 1034, 1036, 1052; Pub. L. 111–255, § 3(c), (e), Oct. 5, 2010, 124 Stat. 2641; Pub. L. 111–296, title I, § 103(c)(1), Dec. 13, 2010, 124 Stat. 3191; Pub. L. 111–309, title I, § 110(a), 111, title II, §§ 205(a), (b), (f)(1), Dec. 15, 2010, 124 Stat. 3288–3290; Pub. L. 112–78, title III, §§ 310(a), 311, Dec. 23, 2011, 125 Stat. 1286; Pub. L. 112–96, title III, §§ 3101(a), 3102,

Feb. 22, 2012, 126 Stat. 191; Pub. L. 112–240, title VI, §§ 621(a), 622, 623, 642(b)(2), Jan. 2, 2013, 126 Stat. 2352, 2358; Pub. L. 113–67, div. A, title II, § 202(a), (b)(1), div. B, title II, §§ 1201(a), 1202, Dec. 26, 2013, 127 Stat. 1177, 1198, 1199; Pub. L. 113–93, title II, §§ 201(a), 202, 203, Apr. 1, 2014, 128 Stat. 1045, 1046; Pub. L. 114–10, title II, §§ 211(a), 212(b), title III, § 302, Apr. 16, 2015, 129 Stat. 151, 152, 158; Pub. L. 114–63, § 2, Oct. 7, 2015, 129 Stat. 549; Pub. L. 114–198, title VII, § 706(b)(1), July 22, 2016, 130 Stat. 754; Pub. L. 114–255, div. A, title V, §§ 5005(a)(1), (3), (6), (b)(1), (c)(2), 5006(a), (b), div. 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, 133 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;”;

(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 1395l 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 fol-

lows: “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 1396o(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 1396o(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 1396o(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 1395o(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)(i)(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(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(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 indi-

viduals 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 non-institutional 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 1395f(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 1396o 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, 1396o, 1396o-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 3007 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 1396o, 1396o–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 pro-

visions 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 1396o 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 1396o 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 calendar [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 1396o 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 1396o 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 1396o 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 1395f 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(f)(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 1396o 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) Expediently 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, §201(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 award 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 1396o, 1396o–1, 1396p, 1396p–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 waiver-

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 outstated 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 multi-state 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 non-profit 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 1396o 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-

published 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. 1396o(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, 1396o, 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. 1395f(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 ap-

proved, 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-