

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 section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (j) of this section and section 1396r-4(f) of this title) of the total amount expended during such quarter as medical assistance under the State plan; plus

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

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1396r(e)(1) of this title (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1396r(e)(7) of this title; plus

(D) for each calendar quarter during—

(i) fiscal year 1991, an amount equal to 90 percent,

(ii) fiscal year 1992, an amount equal to 85 percent,

(iii) fiscal year 1993, an amount equal to 80 percent, and

(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1396r(g) of this title; plus

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this subchapter by, children of families for whom English is not the primary language; plus

(3) an amount equal to—

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

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

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

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

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

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization¹ or by an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, under a contract entered into under section 1396a(d) of this title; and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1396u-2(c)(2) of this title; and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1396r-8(g) of this title;

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this subchapter and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this subchapter and who have Sickle Cell Disease; and

(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(H)(i)² 90 percent of the sums expended during the quarter as are attributable to the

design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1396a(ee) of this title (including a system described in paragraph (2)(B) thereof),³ and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies,³ plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1320b-7(d) of this title; plus

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

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter which are attributable to the establishment and operation of (including the training of personnel employed by) a State Medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1396r(g)(3)(B) of this title, an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title.

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1320a-1 of this title.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

¹ So in original. Probably should be "a quality improvement organization".

² So in original. There is no subpar. (G).

³ So in original. The comma probably should be a semicolon.

(A) \$125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this subchapter.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this subchapter shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this subchapter) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this subchapter or subchapter XVIII or debarred by any Federal agency, or subject to a civil money penalty under this chapter.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in subsection (w)(3)(A))⁴ that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Treatment of educationally-related services

Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [20 U.S.C. 1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act [20 U.S.C. 1431 et seq.].

(d) Estimates of State entitlement; installments; adjustments to reflect overpayments or underpayments; time for recovery or adjustment; uncollectable or discharged debts; obligated appropriations; disputed claims

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its

political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d)

⁴ See References in Text note below.

of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1316(d) of this title, and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1396r-4(c) of this title during such fiscal year.

(e) Transition costs of closures or conversions permitted

A State plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1395uu of this title.

(f) Limitation on Federal participation in medical assistance

(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this sec-

tion shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133½ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter.

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

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

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1396o of this title at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

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

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII), 1396a(a)(10)(A)(i)(VIII), 1396a(a)(10)(A)(i)(IX),

1396a(a)(10)(A)(ii)(IX), 1396a(a)(10)(A)(ii)(X),
 1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV),
 or⁵ 1396a(a)(10)(A)(ii)(XV),
 1396a(a)(10)(A)(ii)(XVI), 1396a(a)(10)(A)(ii)(XVII),
 1396a(a)(10)(A)(ii)(XVIII), 1396a(a)(10)(A)(ii)(XIX),
 1396a(a)(10)(A)(ii)(XX), 1396a(a)(10)(A)(ii)(XXI),
 1396a(a)(10)(A)(ii)(XXII), 1396d(p)(1) of this title
 or for any individual—

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

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

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, or who is a PACE program eligible individual enrolled in a PACE program under section 1396u-4 of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title,

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

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e-9(d)⁴ of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for

which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to

⁵So in original. The word "or" probably should precede "1396d(p)(1)".

the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to $33\frac{1}{2}$ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(h) Repealed. Pub. L. 100-203, title IV, § 4211(g)(1), Dec. 22, 1987, 101 Stat. 1330-205

(i) Payment for organ transplants; item or service furnished by excluded individual, entity, or physician; other restrictions

Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title;

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1395y(o) of this title and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments;

(D) beginning on July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1396a(kk)(8) of this title) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1396a(l) of this title; or

(E) with respect to any amount expended for such an item or service furnished during calendar quarters beginning on or after October 1, 2017, subject to section 1396a(kk)(4)(A)(ii)(II) of this title, within a geographic area that is subject to a moratorium imposed under section 1395cc(j)(7) of this title by a provider or supplier that meets the requirements specified in subpara-

graph (C)(iii) of such section, during the period of such moratorium; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1395x(k) of this title for purposes of subchapter XVIII; and if such hospital has in effect such a utilization review plan for purposes of subchapter XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this subchapter; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1395x(k) of this title; or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of subchapter XVIII because of section 1395y(c) of this title; or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1395l(h) of this title for such tests performed for an individual enrolled under part B of subchapter XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1396r(h) of this title or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this subchapter or subchapter XI or for legal expenses in defense of an exclusion or civil money penalty under this subchapter or subchapter XI if there is no reasonable legal ground for the provider's case; or

(9) with respect to any amount expended for non-emergency transportation authorized

under section 1396a(a)(4) of this title, unless the State plan provides for the methods and procedures required under section 1396a(a)(30)(A) of this title; or

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1396r-8 of this title with respect to such drugs or unless section 1396r-8(a)(3) of this title applies;³

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1396r-8(k) of this title) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in section 1396r-8(a)(7) of this title, unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section;

(D) with respect to any amount expended for reimbursement to a pharmacy under this subchapter for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this subchapter (other than with respect to a reasonable restocking fee for such drug); and

(E) with respect to any amount expended for a covered outpatient drug for which a suspension under section 1396r-8(c)(4)(B)(ii)(II) of this title is in effect; or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1396a(x) of this title, unless the claim for the services includes the unique physician identifier provided under such system; or

(12) with respect to any amounts expended for—

(A) a vacuum erection system that is not medically necessary; or

(B) the insertion, repair, or removal and replacement of a penile prosthetic implant (unless such insertion, repair, or removal and replacement is medically necessary); or

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1396s of this title; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.]; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or

service not covered under a State plan under this subchapter; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1395x(o) of this title and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before December 17, 1999;

(21) with respect to amounts expended for covered outpatient drugs described in section 1396r-8(d)(2)(C) of this title (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and section 1396r-8(d)(2)(K) of this title (relating to drugs when used for treatment of sexual or erectile dysfunction);

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1320b-7(d)(1)(A) of this title to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this subchapter, unless the requirement of section 1396a(a)(46)(B) of this title is met;

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1396r-8(k)(2) of this title) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad;

(24) if a State is required to implement an asset verification program under section 1396w of this title and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan;

(25) with respect to any amounts expended for medical assistance for individuals for

whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary);

(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i)⁶ other than medical assistance provided through benchmark coverage described in section 1396u-7(b)(1) of this title or benchmark equivalent coverage described in section 1396u-7(b)(2) of this title; or

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1395x(n) of this title and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of subchapter XVIII, including, as applicable, under a competitive acquisition program under section 1395w-3 of this title in an area of the State.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1396u-2(a)(1)(B) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Adjustment of amount

Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1396m of this title.

(k) Technical assistance to States

The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this subchapter.

(l) Electronic visit verification system for personal care services and home health care services

(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this subchapter (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2020 (or, in the case of home health care serv-

⁶ Probably means subclause (VIII) of subsection (a)(10)(A)(i) of section 1396a of this title.

ices, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

(A) in the case of personal care services—

(i) for calendar quarters in 2020, by .25 percentage points;

(ii) for calendar quarters in 2021, by .5 percentage points;

(iii) for calendar quarters in 2022, by .75 percentage points; and

(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

(B) in the case of home health care services—

(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

(ii) for calendar quarters in 2025, by .5 percentage points;

(iii) for calendar quarters in 2026, by .75 percentage points; and

(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

(i) is minimally burdensome;

(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

(iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 300jj-19 of this title);

(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of December 13, 2016, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

(i) in the case of personal care services, for calendar quarters in 2020; and

(ii) in the case of home health care services, for calendar quarters in 2023.

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

(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii) in implementing such a system, has encountered unavoidable system delays.

(5) In this subsection:

(A) The term “electronic visit verification system” means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

(i) the type of service performed;

(ii) the individual receiving the service;

(iii) the date of the service;

(iv) the location of service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

(B) The term “home health care services” means services described in section 1396d(a)(7) of this title provided under a State plan under this subchapter (or under a waiver of the plan).

(C) The term “personal care services” means personal care services provided under a State plan under this subchapter (or under a waiver of the plan), including services provided under section 1396d(a)(24), 1396n(c), 1396n(i), 1396n(j), or 1396n(k) of this title or under a waiver⁷ under section 1315 of this title.

(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(m) “Medicaid managed care organization” defined; duties and functions of Secretary; payments to States; reporting requirements; remedies

(1)(A) The term “medicaid managed care organization” means a health maintenance organization, an eligible organization with a contract under section 1395mm of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1396a(w) of this title and—

⁷ So in original. Probably should be “waiver”.

(i) makes services it provides to individuals eligible for benefits under this subchapter accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this subchapter are in no case held liable for debts of the organization in case of the organization's insolvency.

An organization that is a qualified health maintenance organization (as defined in section 300e-9(d)⁴ of this title) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 300e-11(a) and (b) of this title.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if—

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(ii) Repealed. Pub. L. 105-33, title IV, §4703(a), Aug. 5, 1997, 111 Stat. 495.

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this subchapter and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1396u-2(a)(4) of this title, and (II) provides for notification in accordance with such section of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services;³

(viii) such contract provides for disclosure of information in accordance with section 1320a-3 of this title and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1395mm(i)(8) of this title;

(xi) such contract provides for maintenance of sufficient patient encounter data to identify

the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1396u-2 of this title; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1396r-8 of this title as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1396r-8(b)(2)(A) of this title, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1396r-8 of this title are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.

(B) Subparagraph (A)⁸ except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 254b(d)(1)(A) or 254c(d)(1) of this title,⁴ and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title and, to the extent required by section 1396a(a)(10)(D) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,⁴ and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this subchapter on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this subchapter on a prepaid risk basis prior to 1970.

(C) to (E) Repealed. Pub. L. 105-33, title IV, § 4703(b)(1)(A), Aug. 5, 1997, 111 Stat. 495.

(F) Repealed. Pub. L. 105-33, title IV, § 4701(d)(2)(B), Aug. 5, 1997, 111 Stat. 494.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 254b(d)(1)(A) or 254c(d)(1) of this title⁴ or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,⁴ clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this subchapter and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1396d(t)(3) of this title,

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1396d(t)(3) of this title with the State.

(3) No payment shall be made under this subchapter to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1396u-2(a)(1) of this title) under the State plan under this subchapter (or under a waiver of the plan) unless the State—

(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1396u-2(d)(5) of this title; and

(B) beginning on January 1, 2018, complies with the requirement specified in section 1396u-2(d)(6)(A) of this title.

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 300e-9(d)⁴ of this title) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services,

⁸ So in original. Probably should be followed by a comma.

and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 300e-17(b) of this title), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this subchapter;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection, or

(II) to an individual or to any other entity under this subsection,³ or

(v) fails to comply with the requirements of section 1395mm(i)(8) of this title,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than \$25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than \$100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such

subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(6)(A) For purposes of this subsection and section 1396a(e)(2)(A) of this title, in the case of the State of New Jersey, the term “contract” shall be deemed to include an undertaking by the State agency, in the State plan under this subchapter, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this subchapter;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this subchapter for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual reapproval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1396n(b) of this title.

(7) Payment shall be made under this subchapter to a State for expenditures for capitation payments described in section 438.6(e) of title 42, Code of Federal Regulations (or any successor regulation).

(8)(A) The State agency administering the State plan under this subchapter may have reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State to the extent the State agency is permitted to access such databases under State law.

(B) Such State agency may facilitate reasonable access, as determined by the State, to 1 or

more prescription drug monitoring program databases administered or accessed by the State, to same extent that the State agency is permitted under State law to access such databases, for—

(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries; and

(ii) any managed care entity (as defined under section 1396u-2(a)(1)(B) of this title) that has a contract with the State under this subsection or under section 1396d(t)(3) of this title.

(C) Such State agency may share information in such databases, to the same extent that the State agency is permitted under State law to share information in such databases, with—

(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries; and

(ii) any managed care entity (as defined under section 1396u-2(a)(1)(B) of this title) that has a contract with the State under this subsection or under section 1396d(t)(3) of this title.

(9)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020 (and before fiscal year 2024), in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1396d(b) of this title (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1396d(y) of this title.

(B) Expenditures described in this subparagraph, with respect to a fiscal year to which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

(I) in the case of a State described in subparagraph (C), to apply a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of sec-

tion 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this subchapter (or a waiver of the plan) that is equal to or greater than 85 percent.

(D) For purposes of this paragraph:

(i) The term “managed care entity” means a medicaid managed care organization described in section 1396u-2(a)(1)(B)(i) of this title.

(ii) The term “minimum medical loss ratio” means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this subchapter (or a waiver of the plan).

(iii) The term “other specified entity” means—

(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).

(n) Repealed. Pub. L. 100-93, § 8(h)(1), Aug. 18, 1987, 101 Stat. 694

(o) Restrictions on authorized payments to States

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this subchapter to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 1167(1) of title 29), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) Assignment of rights of payment; incentive payments for enforcement and collection

(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1396k of this title, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined

under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) “State medicaid fraud control unit” defined

For the purposes of this section, the term “State medicaid fraud control unit” means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this subchapter to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this subchapter.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this subchapter.

(3) The entity’s function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this subchapter; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1320a-7b(f)(1) of this title), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this subchapter.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this subchapter;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities and of patients (who are receiving medical assistance under the State plan under this subchapter (or waiver of such plan)) in a noninstitutional or other setting; and

(iii) procedures for acting upon such complaints under the criminal laws of the State

or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term “board and care facility” means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this subchapter) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity’s activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r) Mechanized claims processing and information retrieval systems; operational, etc., requirements

(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this subchapter, a State must, in addition to meeting the requirements of paragraph (3), have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of subchapter XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this subchapter or subchapter XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under subchapter XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this subchapter or subchapter XVIII; and

(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of subchapter XI;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States.

(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

(A) Not later than September 1, 2010:

(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this subchapter.

(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this subchapter with respect to items or services for which States provide medical assistance under this subchapter and no national correct coding methodologies have been established under such Initiative with respect to subchapter XVIII.

(iii) Notify States of—

(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(II) how States are to incorporate such methodologies into claims filed under this subchapter.

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).

(s) Limitations on certain physician referrals

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in subsection (h)(6) of section 1395nn of this title) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under subchapter XVIII if such subchapter provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this subchapter in the same manner as such subsections apply to a provider of such a service for which payment may be made under such subchapter.

(t) Payments to encourage adoption and use of certified EHR technology

(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection—

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum

amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term “Medicaid provider” means—

(A) an eligible professional (as defined in paragraph (3)(B))—

(i) who is not hospital-based and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children’s hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1395w-4(o) and 1395w-23(l) of this title with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under subsection (m) or section 1396u-2 of this title).

(3) In this subsection and subsection (a)(3)(F):

(A) The term “certified EHR technology” means a qualified electronic health record (as defined in⁹ 300jj(13) of this title) that is certified pursuant to section 300jj-11(c)(5) of this title as meeting standards adopted under section 300jj-14 of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term “eligible professional” means a—

(i) physician;

(ii) dentist;

(iii) certified nurse mid-wife;

(iv) nurse practitioner; and

(v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term “average allowable costs” means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

(i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and

(ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term “hospital-based” means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual’s professional services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term “net average allowable costs” means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term “needy individual” means, with respect to a Medicaid provider, an individual—

(i) who is receiving assistance under this subchapter;

(ii) who is receiving assistance under subchapter XXI;

(iii) who is furnished uncompensated care by the provider; or

(iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual’s ability to pay.

⁹ So in original. The word “section” probably should appear.

(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—

(i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));

(ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and

(iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid¹⁰ provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be $\frac{2}{3}$ of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

(i) in the aggregate the product of—

(I) the overall hospital EHR amount for the provider computed under subparagraph (B); and

(II) the Medicaid share for such provider computed under subparagraph (C);

(ii) in any year 50 percent of the product described in clause (i); and

(iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1395ww(n)(2)(A) of this title for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1395ww(n)(2)(C) of this title for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a pe-

riod specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1395ww(n)(2)(D) of this title for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this subchapter and who are not described in section 1395ww(n)(2)(D)(i) of this title. In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under subsection (m) or section 1396u-2 of this title).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

(ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1395w-4(o) or 1395ww(n) of this title.

¹⁰ So in original. Probably should be preceded by "a".

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1395w-4(o) and 1395w-23(l) of this title and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under subchapter XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this subchapter, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Com-

merce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u) Limitation of Federal financial participation in erroneous medical assistance expenditures

(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this subchapter exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the

amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1396k(a)(1)(C) or 602(a)(26)(C)⁴ of this title or with respect to payments made in violation of section 1396e of this title.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1396r-1(b)(1) of this title), for items and services described in subsection (a) of section 1396r-1a of this title provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1396r-1b of this title during a presumptive eligibility period under such section, or¹¹ for medical assistance provided to an individual described in subsection (a) of section 1396r-1c of this title during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1396a(a)(47)(B) of this title to be a qualified entity for such purpose.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1383c of this title and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall es-

tablish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this subchapter for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v) Medical assistance to aliens not lawfully admitted for permanent residence

(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2) and (4), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter (other than the requirement of the receipt of aid or assistance under subchapter IV, supplemental security income benefits under subchapter XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this subchapter) to provide medical assistance under this subchapter, notwithstanding sections 1611(a), 1612(b), 1613, and 1631 of title 8, to children and pregnant women who are lawfully residing in the United States (including battered individuals described in section 1641(c) of title 8) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) Pregnant women

Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

¹¹ So in original. The word "or" probably should not appear.

(ii) Children

Individuals under 21 years of age, including optional targeted low-income children described in section 1396d(u)(2)(B) of this title.

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State's ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.

(w) Prohibition on use of voluntary contributions, and limitation on use of provider-specific taxes to obtain Federal financial participation under medicaid

(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for ad-

ministrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this subchapter during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term "impermissible tax" means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term “provider-related donation” means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term “bona fide provider-related donation” means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this subchapter to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this subchapter and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term “health care related tax” means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term “broad-based health care related tax” means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which,

except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this subchapter or subchapter XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this subchapter or subchapter XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related

tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this subchapter as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this subchapter for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this subchapter or under subchapter XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this subchapter) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, "5.5 percent" shall be substituted for "6 percent" each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this subchapter nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term "State base percentage" means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of December 12, 1991.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in section 1396a(a)(2) of this title, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

- (i) Inpatient hospital services.
- (ii) Outpatient hospital services.
- (iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).
- (iv) Services of intermediate care facilities for the mentally retarded.
- (v) Physicians' services.
- (vi) Home health care services.
- (vii) Outpatient prescription drugs.
- (viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).
- (ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

- (i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;
- (ii) is a person with an ownership or control interest (as defined in section 1320a-3(a)(3) of this title) in the provider;
- (iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or
- (iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this subchapter is operated under a waiver granted under section 1315 of this title.

(E) The "State fiscal year" means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term "tax" includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

(x) Satisfactory documentary evidence of citizenship or nationality by individual declaring to be citizen or national of United States

(1) For purposes of section 1396a(a)(46)(B)(i) of this title, the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this subchapter—

(A) and is entitled to or enrolled for benefits under any part of subchapter XVIII;

(B) and is receiving—

(i) disability insurance benefits under section 423 of this title or monthly insurance benefits under section 402 of this title based on such individual's disability (as defined in section 423(d) of this title); or

(ii) supplemental security income benefits under subchapter XVI;

(C) and with respect to whom—

(i) child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of subchapter IV;

(D) pursuant to the application of section 1396a(e)(4) of this title (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or

(E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) For purposes of this subsection, the term "satisfactory documentary evidence of citizenship or nationality" means—

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

(i) A United States passport.

(ii) Form N-550 or N-570 (Certificate of Naturalization).

(iii) Form N-560 or N-561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver's license or other identity document described in section 1324a(b)(1)(D) of title 8, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

(II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations

authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

(vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

(C) The following are documents described in this subparagraph:

(i) A certificate of birth in the United States.

(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).

(iii) Form I-197 (United States Citizen Identification Card).

(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).

(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

(D) The following are documents described in this subparagraph:

(i) Any identity document described in section 1324a(b)(1)(D) of title 8.

(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

(E) A reference in this paragraph to a form includes a reference to any successor form.

(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1396a(a)(46)(B)(i) of this title, the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1320b-7(d)(4)(A) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in subparagraph (A) or (B) of section 1396a(a)(46) of this title, the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1396a(e)(4) of this title that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.

(y) Payments for establishment of alternate non-emergency services providers

(1) Payments

In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for pay-

ments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1396o-1(e)(5)(B)¹² of this title), or networks of such providers.

(2) Limitation

The total amount of payments under this subsection shall not exceed \$50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) Preference

In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

(A) serve rural or underserved areas where beneficiaries under this subchapter may not have regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) Form and manner of payment

Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a).

(z) Medicaid transformation payments

(1) In general

In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this subchapter.

(2) Permissible uses of funds

The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

(B) Methods for improving rates of collection from estates of amounts owed under this subchapter.

(C) Methods for reducing waste, fraud, and abuse under the program under this subchapter, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

(D) Implementation of a medication risk management program as part of a drug use review program under section 1396r-8(g) of this title.

(E) Methods in reducing, in clinically appropriate ways, expenditures under this sub-

¹²So in original. Probably should be section "1396o-1(e)(4)(B)".

chapter for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) Application; terms and conditions

(A) In general

No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

(B) Terms and conditions

Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

(C) Annual report

Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

- (i) the specific uses of such payment;
- (ii) an assessment of quality improvements and clinical outcomes under such programs; and
- (iii) estimates of cost savings resulting from such programs.

(4) Funding

(A) Limitation on funds

The total amount of payments under this subsection shall be equal to, and shall not exceed—

- (i) \$75,000,000 for fiscal year 2007; and
- (ii) \$75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(B) Allocation of funds

The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

(C) Form and manner of payment

Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a). There is no requirement for State matching funds to receive payments under this subsection.

(5) Medication risk management program

(A) In general

For purposes of this subsection, the term “medication risk management program” means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) Elements

Such program may include the following elements:

- (i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.
- (ii) On an ongoing basis provide outlier physicians—
 - (I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;
 - (II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician’s care; and
 - (III) applicable best practice guidelines and empirical references.
- (iii) Monitor outlier physician’s prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) Targeted beneficiaries

For purposes of this paragraph, the term “targeted beneficiaries” means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

(aa) Demonstration project to increase substance use provider capacity

(1) In general

Not later than the date that is 180 days after October 24, 2018, the Secretary shall, in consultation, as appropriate, with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, conduct a 54-month demonstration project for the purpose described in paragraph (2) under which the Secretary shall—

- (A) for the first 18-month period of such project, award planning grants described in paragraph (3); and
- (B) for the remaining 36-month period of such project, provide to each State selected under paragraph (4) payments in accordance with paragraph (5).

(2) Purpose

The purpose described in this paragraph is for each State selected under paragraph (4) to increase the treatment capacity of providers participating under the State plan (or a waiver of such plan) to provide substance use dis-

order treatment or recovery services under such plan (or waiver) through the following activities:

(A) For the purpose described in paragraph (3)(C)(i), activities that support an ongoing assessment of the behavioral health treatment needs of the State, taking into account the matters described in subclauses (I) through (IV) of such paragraph.

(B) Activities that, taking into account the results of the assessment described in subparagraph (A), support the recruitment, training, and provision of technical assistance for providers participating under the State plan (or a waiver of such plan) that offer substance use disorder treatment or recovery services.

(C) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that—

(i) are authorized to dispense drugs approved by the Food and Drug Administration for individuals with a substance use disorder who need withdrawal management or maintenance treatment for such disorder; and

(ii) are qualified under applicable State law to provide substance use disorder treatment or recovery services.

(D) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that have the qualifications to address the treatment or recovery needs of—

(i) individuals enrolled under the State plan (or a waiver of such plan) who have neonatal abstinence syndrome, in accordance with guidelines issued by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists relating to maternal care and infant care with respect to neonatal abstinence syndrome;

(ii) pregnant women, postpartum women, and infants, particularly the concurrent treatment, as appropriate, and comprehensive case management of pregnant women, postpartum women and infants, enrolled under the State plan (or a waiver of such plan);

(iii) adolescents and young adults between the ages of 12 and 21 enrolled under the State plan (or a waiver of such plan); or

(iv) American Indian and Alaska Native individuals enrolled under the State plan (or a waiver of such plan).

(3) Planning grants

(A) In general

The Secretary shall, with respect to the first 18-month period of the demonstration project conducted under paragraph (1), award planning grants to at least 10 States selected in accordance with subparagraph (B) for purposes of preparing an application

described in paragraph (4)(C) and carrying out the activities described in subparagraph (C).

(B) Selection

In selecting States for purposes of this paragraph, the Secretary shall—

(i) select States that have a State plan (or waiver of the State plan) approved under this subchapter;

(ii) select States in a manner that ensures geographic diversity; and

(iii) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

(C) Activities described

Activities described in this subparagraph are, with respect to a State, each of the following:

(i) Activities that support the development of an initial assessment of the behavioral health treatment needs of the State to determine the extent to which providers are needed (including the types of such providers and geographic area of need) to improve the network of providers that treat substance use disorders under the State plan (or waiver), including the following:

(I) An estimate of the number of individuals enrolled under the State plan (or a waiver of such plan) who have a substance use disorder.

(II) Information on the capacity of providers to provide substance use disorder treatment or recovery services to individuals enrolled under the State plan (or waiver), including information on providers who provide such services and their participation under the State plan (or waiver).

(III) Information on the gap in substance use disorder treatment or recovery services under the State plan (or waiver) based on the information described in subclauses (I) and (II).

(IV) Projections regarding the extent to which the State participating under the demonstration project would increase the number of providers offering substance use disorder treatment or recovery services under the State plan (or waiver) during the period of the demonstration project.

(ii) Activities that, taking into account the results of the assessment described in clause (i), support the development of State infrastructure to, with respect to the provision of substance use disorder treatment or recovery services under the State plan (or a waiver of such plan), recruit prospective providers and provide training and technical assistance to such providers.

(D) Funding

For purposes of subparagraph (A), there is appropriated, out of any funds in the Treasury not otherwise appropriated, \$50,000,000, to remain available until expended.

(4) Post-planning states**(A) In general**

The Secretary shall, with respect to the remaining 36-month period of the demonstration project conducted under paragraph (1), select not more than 5 States in accordance with subparagraph (B) for purposes of carrying out the activities described in paragraph (2) and receiving payments in accordance with paragraph (5).

(B) Selection

In selecting States for purposes of this paragraph, the Secretary shall—

- (i) select States that received a planning grant under paragraph (3);
- (ii) select States that submit to the Secretary an application in accordance with the requirements in subparagraph (C), taking into consideration the quality of each such application;
- (iii) select States in a manner that ensures geographic diversity; and
- (iv) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

(C) Applications**(i) In general**

A State seeking to be selected for purposes of this paragraph shall submit to the Secretary, at such time and in such form and manner as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require, in addition to the following:

- (I) A proposed process for carrying out the ongoing assessment described in paragraph (2)(A), taking into account the results of the initial assessment described in paragraph (3)(C)(i).
- (II) A review of reimbursement methodologies and other policies related to substance use disorder treatment or recovery services under the State plan (or waiver) that may create barriers to increasing the number of providers delivering such services.
- (III) The development of a plan, taking into account activities carried out under paragraph (3)(C)(ii), that will result in long-term and sustainable provider networks under the State plan (or waiver) that will offer a continuum of care for substance use disorders. Such plan shall include the following:
 - (aa) Specific activities to increase the number of providers (including providers that specialize in providing sub-

stance use disorder treatment or recovery services, hospitals, health care systems, Federally qualified health centers, and, as applicable, certified community behavioral health clinics) that offer substance use disorder treatment, recovery, or support services, including short-term detoxification services, outpatient substance use disorder services, and evidence-based peer recovery services.

(bb) Strategies that will incentivize providers described in subparagraphs (C) and (D) of paragraph (2) to obtain the necessary training, education, and support to deliver substance use disorder treatment or recovery services in the State.

(cc) Milestones and timeliness for implementing activities set forth in the plan.

(dd) Specific measurable targets for increasing the substance use disorder treatment and recovery provider network under the State plan (or a waiver of such plan).

(IV) A proposed process for reporting the information required under paragraph (6)(A), including information to assess the effectiveness of the efforts of the State to expand the capacity of providers to deliver substance use disorder treatment or recovery services during the period of the demonstration project under this subsection.

(V) The expected financial impact of the demonstration project under this subsection on the State.

(VI) A description of all funding sources available to the State to provide substance use disorder treatment or recovery services in the State.

(VII) A preliminary plan for how the State will sustain any increase in the capacity of providers to deliver substance use disorder treatment or recovery services resulting from the demonstration project under this subsection after the termination of such demonstration project.

(VIII) A description of how the State will coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1315 of this title for the delivery of substance use services under the State plan, as applicable.

(ii) Consultation

In completing an application under clause (i), a State shall consult with relevant stakeholders, including Medicaid managed care plans, health care providers, and Medicaid beneficiary advocates, and include in such application a description of such consultation.

(5) Payment**(A) In general**

For each quarter occurring during the period for which the demonstration project is

conducted (after the first 18 months of such period), the Secretary shall pay under this subsection, subject to subparagraph (C), to each State selected under paragraph (4) an amount equal to 80 percent of so much of the qualified sums expended during such quarter.

(B) Qualified sums defined

For purposes of subparagraph (A), the term “qualified sums” means, with respect to a State and a quarter, the amount equal to the amount (if any) by which the sums expended by the State during such quarter attributable to substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan) exceeds 1/4 of such sums expended by the State during fiscal year 2018 attributable to substance use disorder treatment or recovery services.

(C) Non-duplication of payment

In the case that payment is made under subparagraph (A) with respect to expenditures for substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan), payment may not also be made under subsection (a) with respect to expenditures for the same services so furnished.

(6) Reports

(A) State reports

A State receiving payments under paragraph (5) shall, for the period of the demonstration project under this subsection, submit to the Secretary a quarterly report, with respect to expenditures for substance use disorder treatment or recovery services for which payment is made to the State under this subsection, on the following:

- (i) The specific activities with respect to which payment under this subsection was provided.
- (ii) The number of providers that delivered substance use disorder treatment or recovery services in the State under the demonstration project compared to the estimated number of providers that would have otherwise delivered such services in the absence of such demonstration project.
- (iii) The number of individuals enrolled under the State plan (or a waiver of such plan) who received substance use disorder treatment or recovery services under the demonstration project compared to the estimated number of such individuals who would have otherwise received such services in the absence of such demonstration project.
- (iv) Other matters as determined by the Secretary.

(B) CMS reports

(i) Initial report

Not later than October 1, 2020, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the

Assistant Secretary for Mental Health and Substance Use, submit to Congress an initial report on—

- (I) the States awarded planning grants under paragraph (3);
- (II) the criteria used in such selection; and
- (III) the activities carried out by such States under such planning grants.

(ii) Interim report

Not later than October 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an interim report—

- (I) on activities carried out under the demonstration project under this subsection;
- (II) on the extent to which States selected under paragraph (4) have achieved the stated goals submitted in their applications under subparagraph (C) of such paragraph;
- (III) with a description of the strengths and limitations of such demonstration project; and
- (IV) with a plan for the sustainability of such project.

(iii) Final report

Not later than October 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress a final report—

- (I) providing updates on the matters reported in the interim report under clause (ii);
- (II) including a description of any changes made with respect to the demonstration project under this subsection after the submission of such interim report; and
- (III) evaluating such demonstration project.

(C) AHRQ report

Not later than 3 years after October 24, 2018, the Director of the Agency for Healthcare Research and Quality, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a summary on the experiences of States awarded planning grants under paragraph (3) and States selected under paragraph (4).

(7) Data sharing and best practices

During the period of the demonstration project under this subsection, the Secretary shall, in collaboration with States selected under paragraph (4), facilitate data sharing and the development of best practices between such States and States that were not so selected.

(8) CMS funding

There is appropriated, out of any funds in the Treasury not otherwise appropriated, \$5,000,000 to the Centers for Medicare & Medicaid Services for purposes of implementing this subsection. Such amount shall remain available until expended.

(bb) Supplemental payment reporting requirements**(1) Collection and availability of supplemental payment data****(A) In general**

Not later than October 1, 2021, the Secretary shall establish a system for each State to submit reports, as determined appropriate by the Secretary, on supplemental payments data, as a requirement for a State plan or State plan amendment that would provide for a supplemental payment.

(B) Requirements

Each report submitted by a State in accordance with the requirement established under subparagraph (A) shall include the following:

(i) An explanation of how supplemental payments made under the State plan or a State plan amendment will result in payments that are consistent with section 1396a(a)(30)(A) of this title, including standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment.

(ii) The criteria used to determine which providers are eligible to receive the supplemental payment.

(iii) A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including—

(I) data on the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from 1 or more fiscal years, data on the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment;

(II) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data to be used as the basis for calculations regarding the amount or distribution of the supplemental payment; and

(III) the timing of the supplemental payment made to each eligible provider.

(iv) An assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits.

(v) If not already submitted, an upper payment limit demonstration under section 447.272 of title 42, Code of Federal Regulations (as such section is in effect as of December 27, 2020).

(C) Public availability

The Secretary shall make all reports and related data submitted under this paragraph publicly available on the website of the Centers for Medicare & Medicaid Services on a timely basis.

(2) Supplemental payment defined**(A) In general**

Subject to subparagraph (B), in this subsection, the term “supplemental payment” means a payment to a provider that is in addition to any base payment made to the provider under the State plan under this subchapter or under demonstration authority.

(B) DSH payments excluded

Such term does not include a disproportionate share hospital payment made under section 1396r-4 of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1903, as added Pub. L. 89-97, title I, §121(a), July 30, 1965, 79 Stat. 349; amended Pub. L. 90-248, title II, §§220(a), 222(c), (d), 225(a), 229(c), 241(f)(5), Jan. 2, 1968, 81 Stat. 898, 901, 902, 904, 917; Pub. L. 90-364, title III, §303(a)(1), June 28, 1968, 82 Stat. 274; Pub. L. 91-56, §2(a), Aug. 9, 1969, 83 Stat. 99; Pub. L. 92-603, title II, §§207(a), 221(c)(6), 224(c), 225, 226(e), 229(c), 230, 233(c), 235(a), 237(a)(1), 249B, 278(b)(1), (5), (7), (16), 290, 295, 299E(a), Oct. 30, 1972, 86 Stat. 1379, 1389, 1395, 1396, 1404, 1410, 1411, 1414, 1415, 1428, 1453, 1454, 1457, 1459, 1462; Pub. L. 93-66, title II, §234(a), July 9, 1973, 87 Stat. 160; Pub. L. 93-233, §§13(a)(11), (12), 18(r)-(v), (x)(5), (6), (y)(1), Dec. 31, 1973, 87 Stat. 963, 971-973; Pub. L. 94-182, title I, §§110(a), 111(b), Dec. 31, 1975, 89 Stat. 1054; Pub. L. 94-460, title II, §202(a), Oct. 8, 1976, 90 Stat. 1957; Pub. L. 94-552, §1, Oct. 18, 1976, 90 Stat. 2540; Pub. L. 95-83, title I, §105(a)(1), (2), Aug. 1, 1977, 91 Stat. 384; Pub. L. 95-142, §§3(c)(2), 8(c), 10(a), 11(a), 17(a)-(c), 20(a), Oct. 25, 1977, 91 Stat. 1179, 1195, 1196, 1201, 1205; Pub. L. 95-559, §14(c), Nov. 1, 1978, 92 Stat. 2141; Pub. L. 95-626, title I, §102(b)(3), Nov. 10, 1978, 92 Stat. 3551; Pub. L. 96-79, title I, §128, Oct. 4, 1979, 93 Stat. 629; Pub. L. 96-398, title IX, §901, Oct. 7, 1980, 94 Stat. 1609; Pub. L. 96-499, title IX, §§905(b), (c), 961(a), 963, 964, Dec. 5, 1980, 94 Stat. 2618, 2650, 2651; Pub. L. 97-35, title XXI, §§2101(a)(2), 2103(b)(1), 2106(b)(3), 2113(n), 2161, 2163, 2164(a), 2174(b), 2178(a), 2183(a), Aug. 13, 1981, 95 Stat. 786, 788, 792, 795, 803-806, 809, 813, 816; Pub. L. 97-248, title I, §§133(a), 137(a)(1), (2), (b)(11)-(16), (27), (g), 146(b), Sept. 3, 1982, 96 Stat. 373, 376, 378, 379, 381, 394; Pub. L. 97-448, title III, §309(b)(16), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98-369, div. B, title III, §§2303(g)(2), 2363(a)(2), (4), (b), 2364, 2373(b)(11)-(14), July 18, 1984, 98 Stat. 1066, 1106, 1107, 1111, 1112; Pub. L. 98-617, §3(a)(6), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99-272, title IX, §§9503(b), (f), 9507(a), 9512(a), 9517(a), (c)(1), 9518(a), Apr. 7, 1986, 100 Stat. 206, 207, 210, 212, 215, 216; Pub. L. 99-509, title IX, §§9401(e)(2), 9403(g)(2), 9406(a), 9407(c), 9431(b)(2), 9434(a)(1), (2), (b), Oct. 21, 1986, 100 Stat. 2052, 2055, 2057, 2060, 2066, 2068, 2069; Pub. L. 99-514, title XVIII, §1895(c)(2), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 99-603, title I, §121(b)(2), Nov. 6, 1986, 100 Stat. 3390; Pub. L. 100-93, §8(g), (h)(1), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100-203, title IV, §§4112(b), 4113(a)(1), (b)(3), (d)(1), 4118(d)(1), (e)(11), (h)(1),

(p)(5), 4211(d)(1), (g), (i), 4212(c)(1), (2), (d)(1), (e)(2), 4213(b)(2), Dec. 22, 1987, 101 Stat. 1330-149, 1330-150, 1330-152, 1330-155, 1330-159, 1330-204, 1330-205, 1330-207, 1330-212, 1330-213, 1330-219, as amended Pub. L. 100-360, title IV, §411(a)(3)(A), (B)(iii), (k)(6)(B)(x), (7)(A), (D), (10)(D), (G)(ii), July 1, 1988, 102 Stat. 768, 794, 796; Pub. L. 100-360, title II, §202(h)(2), title III, §§301(f), 302(c)(3), (e)(4), title IV, §411(k)(12)(A), (13)(A), July 1, 1988, 102 Stat. 718, 750, 752, 753, 797, 798; Pub. L. 100-485, title VI, §608(d)(26)(K)(ii), (f)(4), Oct. 13, 1988, 102 Stat. 2422, 2424; Pub. L. 101-234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101-239, title VI, §§6401(b), 6411(d)(2), 6901(b)(5)(A), Dec. 19, 1989, 103 Stat. 2259, 2271, 2299; Pub. L. 101-508, title IV, §§4401(a)(1), (b)(1), 4402(b), (d)(3), 4601(a)(3)(A), 4701(b)(2), 4704(b)(1), (2), 4711(c)(2), 4723(a), 4731(a), (b)(2), 4732(a), (b)(2), (c), (d), 4751(b)(1), 4752(a)(2), (b)(1), (e), 4801(a)(8), (e)(16)(A), Nov. 5, 1990, 104 Stat. 1388-143, 1388-159, 1388-163, 1388-164, 1388-166, 1388-170, 1388-172, 1388-187, 1388-194 to 1388-196, 1388-205 to 1388-207, 1388-212, 1388-218; Pub. L. 102-119, §26(i)(1), Oct. 7, 1991, 105 Stat. 607; Pub. L. 102-234, §§2(a), (b)(2), 3(b)(2)(B), 4(a), Dec. 12, 1991, 105 Stat. 1793, 1799, 1803, 1804; Pub. L. 103-66, title XIII, §§13602(b), 13604(a), 13622(a)(2), 13624(a), 13631(c), (h)(1), Aug. 10, 1993, 107 Stat. 619, 621, 632, 636, 643, 645; Pub. L. 104-193, title I, §114(d)(2), Aug. 22, 1996, 110 Stat. 2180; Pub. L. 104-248, §1(b)(1), Oct. 9, 1996, 110 Stat. 3148; Pub. L. 105-12, §9(b)(1), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105-33, title IV, §§4701(b)(1), (2)(A)(v)-(viii), (B), (C), (c), (d)(2), 4702(b)(1), 4703(a), (b)(1), 4705(b), 4706, 4707(b), 4708(a), (d), 4712(b)(2), (c)(2), 4722(a), (b), 4724(a), (b)(1), 4742(a), 4753(a), 4802(b)(2), 4912(b)(2), Aug. 5, 1997, 111 Stat. 492, 493, 495, 500, 501, 505, 506, 509, 514-516, 523, 525, 549, 573; Pub. L. 105-100, title I, §162(4), Nov. 19, 1997, 111 Stat. 2189; Pub. L. 106-31, title III, §3031(a), (b), May 21, 1999, 113 Stat. 103, 104; Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §§604(a)(2)(B), (b)(2), 608(e)-(k), (aa)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-395, 1501A-397, 1501A-398; Pub. L. 106-170, title II, §201(a)(4), (b), title IV, §407(a)-(c), Dec. 17, 1999, 113 Stat. 1893, 1913; Pub. L. 106-354, §2(b)(2)(B), Oct. 24, 2000, 114 Stat. 1383; Pub. L. 106-554, §1(a)(6) [title VII, §§702(c)(1), 710(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-574, 2763A-578; Pub. L. 108-357, title VII, §712(b), Oct. 22, 2004, 118 Stat. 1559; Pub. L. 108-446, title III, §305(j)(1), Dec. 3, 2004, 118 Stat. 2806; Pub. L. 109-91, title I, §104(b), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109-171, title VI, §§6002(b), 6033(a), 6036(a), 6043(b), 6051(a), 6062(c)(1), 6081, Feb. 8, 2006, 120 Stat. 59, 74, 80, 88, 92, 98, 111; Pub. L. 109-432, div. B, title IV, §§403, 405(c)(1)(A), Dec. 20, 2006, 120 Stat. 2994, 2998; Pub. L. 110-28, title VII, §7002(b)(1), May 25, 2007, 121 Stat. 187; Pub. L. 110-252, title VII, §7001(d)(3), June 30, 2008, 122 Stat. 2394; Pub. L. 110-379, §3(a), Oct. 8, 2008, 122 Stat. 4075; Pub. L. 111-3, title II, §§201(b)(2)(A), 211(a)(1)(B), (3), (b)(1)-(3)(A), (4), 214(a), title IV, §401(b), Feb. 4, 2009, 123 Stat. 39, 52-54, 56, 82; Pub. L. 111-5, div. B, title IV, §4201(a), Feb. 17, 2009, 123 Stat. 489; Pub. L. 111-148, title II, §§2001(a)(2)(B), (5)(D), (e)(2)(B), 2004(c)(1), 2102(a)(8), 2202(b), 2303(a)(4)(B), (b)(2)(B), 2402(d)(2)(A), 2501(c)(1), title VI, §§6402(c), (h)(2), 6504(a), (b)(1), 6506(a)(1), 6507, Mar. 23, 2010, 124 Stat. 272, 275, 279, 283, 288, 291, 294, 296, 303, 308, 757, 760, 776-778; Pub. L. 111-157,

§5(a)(2), Apr. 15, 2010, 124 Stat. 1117; Pub. L. 111-309, title II, §205(e), Dec. 15, 2010, 124 Stat. 3290; Pub. L. 114-113, div. O, title V, §503(a)(1), Dec. 18, 2015, 129 Stat. 3020; Pub. L. 114-255, div. A, title V, §§5002, 5005(a)(4), 5008(a), div. B, title XII, §12006(a), div. C, title XVII, §17004(b)(1)(A), Dec. 13, 2016, 130 Stat. 1188, 1192, 1197, 1275, 1332; Pub. L. 115-222, §1(a), July 30, 2018, 132 Stat. 1560; Pub. L. 115-271, title I, §§1003, 1013, 1016(a), title IV, §4001, Oct. 24, 2018, 132 Stat. 3903, 3920, 3922, 3958; Pub. L. 116-16, §§6(a)(2)(A), 8(a), Apr. 18, 2019, 133 Stat. 861, 864; Pub. L. 116-260, div. CC, title II, §§202, 207, 209(a)(3), Dec. 27, 2020, 134 Stat. 2977, 2984, 2986; Pub. L. 117-215, title I, §103(b)(5), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117-328, div. FF, title I, §1262(b)(8), Dec. 29, 2022, 136 Stat. 5682.)

Editorial Notes

REFERENCES IN TEXT

Subsection (w)(3)(A), referred to in subsec. (b)(5), was in the original "section 1902(w)(3)(A)", and was translated as reading "section 1903(w)(3)(A)", meaning section 1903(w)(3)(A) of the Social Security Act, to reflect the probable intent of Congress, because section 1902(w)(3), which is classified to section 1396a(w)(3) of this title, does not contain a subpar. (A), and subsec. (w)(3)(A) of this section relates to health care related taxes.

The Individuals with Disabilities Education Act, referred to in subsec. (c), is title VI of Pub. L. 91-230, Apr. 13, 1970, 84 Stat. 175. Parts B and C of the Act are classified generally to subchapters II (§1411 et seq.) and III (§1431 et seq.), respectively, of chapter 33 of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Internal Revenue Code of 1986, referred to in subsecs. (d)(3)(B)(i) and (w)(3)(F), is classified generally to Title 26, Internal Revenue Code.

Section 300e-9(d) of this title, referred to in subsecs. (g)(1) and (m)(1)(A), (4)(A), was redesignated section 300e-9(c) of this title by Pub. L. 100-517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (i)(16), is Pub. L. 105-12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

Sections 254b and 254c of this title, referred to in subsec. (m)(2)(B)(i)(I), (G), were in the original references to sections 329 and 330 of the Public Health Service Act, act July 1, 1944, which were omitted in the general amendment of subpart I (§254b et seq.) of part D of subchapter II of chapter 6A of this title by Pub. L. 104-299, §2, Oct. 11, 1996, 110 Stat. 3626. Sections 2 and 3(a) of Pub. L. 104-299 enacted new sections 330 and 330A of act July 1, 1944, which are classified, respectively, to sections 254b and 254c of this title.

The Appalachian Regional Development Act of 1965, referred to in subsec. (m)(2)(B)(ii), (G), is Pub. L. 89-4, Mar. 9, 1965, 79 Stat. 5, which was set out in the Appendix to former Title 40, Public Buildings, Property, and Works, and was repealed and reenacted as subtitle IV (§14101 et seq.) of Title 40, Public Buildings, Property, and Works, by Pub. L. 107-217, §§1, 6(b), Aug. 21, 2002, 116 Stat. 1062, 1304.

Section 602 of this title, referred to in subsec. (u)(1)(D)(iv), was repealed and a new section 602 enacted by Pub. L. 104-193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (a)(26)(C).

The Deficit Reduction Act of 2005, referred to in subsec. (x)(5), is Pub. L. 109-171, Feb. 8, 2006, 120 Stat. 4. Section 6036 of the Act amended this section and enacted provisions set out as notes under this section.

For complete classification of this Act to the Code, see Short Title of 2006 Amendment note set out under section 1305 of this title and Tables.

AMENDMENTS

2022—Subsec. (aa)(2)(C)(ii). Pub. L. 117–328, § 1262(b)(8), redesignated cl. (iii) as (ii) and struck out former cl. (ii) which read as follows: “have in effect a registration or waiver under section 823(h) of title 21 for purposes of dispensing narcotic drugs to individuals for maintenance treatment or detoxification treatment and are in compliance with any regulation promulgated by the Assistant Secretary for Mental Health and Substance Use for purposes of carrying out the requirements of such section 823(h); and”.

Pub. L. 117–215 substituted “823(h)” for “823(g)” in two places.

Subsec. (aa)(2)(C)(iii). Pub. L. 117–328, § 1262(b)(8)(C), redesignated cl. (iii) as (ii).

2020—Subsec. (a)(6). Pub. L. 116–260, § 207(b), which directed amendment of concluding provisions by striking out “(as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan (or waiver of such plan))”, was executed by striking out “(as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan)” after “such quarter”, to reflect the probable intent of Congress.

Subsec. (i)(9). Pub. L. 116–260, § 209(a)(3), added par. (9).

Subsec. (q)(4)(A)(ii). Pub. L. 116–260, § 207(a), inserted “and of patients (who are receiving medical assistance under the State plan under this subchapter (or waiver of such plan) in a noninstitutional or other setting” after “patients residing in board and care facilities”.

Subsec. (bb). Pub. L. 116–260, § 202, added subsec. (bb). 2019—Subsec. (i)(10)(C) to (E). Pub. L. 116–16, § 6(a)(2)(A), added subpar. (E) and realigned margins.

Subsec. (i)(12). Pub. L. 116–16, § 8(a), added par. (12).

2018—Subsec. (l)(1). Pub. L. 115–222, § 1(a)(1)(A), substituted “January 1, 2020” for “January 1, 2019” in introductory provisions.

Subsec. (l)(1)(A)(i). Pub. L. 115–222, § 1(a)(1)(B), struck out “2019 and” before “2020”.

Subsec. (l)(4)(A)(i). Pub. L. 115–222, § 1(a)(2), substituted “calendar quarters in 2020” for “calendar quarters in 2019”.

Subsec. (m)(7). Pub. L. 115–271, § 1013, added par. (7).

Subsec. (m)(8). Pub. L. 115–271, § 1016(a), added par. (8).

Subsec. (m)(9). Pub. L. 115–271, § 4001, added par. (9).

Subsec. (aa). Pub. L. 115–271, § 1003, added subsec. (aa).

2016—Subsec. (i)(2)(A). Pub. L. 114–255, § 5005(a)(4)(A)(i), substituted semicolon for comma at end.

Subsec. (i)(2)(D). Pub. L. 114–255, § 5005(a)(4)(A)(ii), (iii), added subpar. (D).

Subsec. (i)(2)(E). Pub. L. 114–255, § 17004(b)(1)(A), added subpar. (E).

Subsec. (i)(21). Pub. L. 114–255, § 5008(a), inserted “section 1396r–8(d)(2)(C) of this title (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and” after “drugs described in”.

Subsec. (i)(27). Pub. L. 114–255, § 5002, substituted “January 1, 2018” for “January 1, 2019”.

Subsec. (l). Pub. L. 114–255, § 12006(a), added subsec. (l). Subsec. (m)(3). Pub. L. 114–255, § 5005(a)(4)(B), added par. (3).

2015—Subsec. (i)(27). Pub. L. 114–113 added par. (27).

2010—Subsec. (a)(3)(E). Pub. L. 111–148, § 2102(a)(8)(A), amended Pub. L. 111–3, § 211(a)(1)(B). See 2009 Amendment note below.

Subsec. (a)(3)(H). Pub. L. 111–148, § 2102(a)(8)(B), amended Pub. L. 111–3, § 211(a)(1)(B). See 2009 Amendment note below.

Subsec. (d)(2)(C). Pub. L. 111–148, § 6506(a)(1)(A), substituted “1 year” for “60 days” in first sentence and “1-year period” for “60 days” in second sentence.

Subsec. (d)(2)(D). Pub. L. 111–148, § 6506(a)(1)(B), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (f)(4). Pub. L. 111–148, § 2402(d)(2)(A), inserted “1396a(a)(10)(A)(ii)(XXII),” after

“1396a(a)(10)(A)(ii)(XXI),”

Pub. L. 111–148, § 2303(a)(4)(B), inserted

“1396a(a)(10)(A)(ii)(XXI),”

“1396a(a)(10)(A)(ii)(XX),”

Pub. L. 111–148, § 2004(c)(1), inserted

“1396a(a)(10)(A)(i)(IX),” after “1396a(a)(10)(A)(i)(VIII),”

Pub. L. 111–148, § 2001(e)(2)(B), inserted

“1396a(a)(10)(A)(ii)(XX),”

“1396a(a)(10)(A)(ii)(XIX),”

Pub. L. 111–148, § 2001(a)(5)(D), inserted

“1396a(a)(10)(A)(i)(VIII),”

“1396a(a)(10)(A)(i)(VII),”

Subsec. (i)(2)(C). Pub. L. 111–148, § 6402(h)(2), added subpar. (C).

Subsec. (i)(25). Pub. L. 111–148, § 6402(c), added par. (25).

Subsec. (i)(26). Pub. L. 111–148, § 2001(a)(2)(B), added par. (26).

Subsec. (m)(2)(A)(xi). Pub. L. 111–148, § 6504(b)(1), inserted “and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary” after “patients”.

Subsec. (m)(2)(A)(xiii). Pub. L. 111–148, § 2501(c)(1), added cl. (xiii).

Subsec. (r)(1)(B)(iv). Pub. L. 111–148, § 6507(1), added cl. (iv).

Subsec. (r)(1)(F). Pub. L. 111–148, § 6504(a), inserted “and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine” after “necessary”.

Subsec. (r)(4). Pub. L. 111–148, § 6507(2), added par. (4).

Subsec. (t)(3)(D). Pub. L. 111–157 substituted “inpatient or emergency room setting” for “setting (whether inpatient or outpatient)”.

Subsec. (t)(3)(E). Pub. L. 111–309, § 205(e)(1), substituted “reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government)” for “reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government)”.

Subsec. (t)(6)(B). Pub. L. 111–309, § 205(e)(2), inserted “and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost” before period at end.

Subsec. (u)(1)(D)(v). Pub. L. 111–148, § 2303(b)(2)(B), inserted “or for medical assistance provided to an individual described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period under such section,” after “section 1396r–1b of this title during a presumptive eligibility period under such section,”

Pub. L. 111–148, § 2202(b), substituted “section, for medical” for “section, or for medical” and inserted before period at end “, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1396a(a)(47)(B) of this title to be a qualified entity for such purpose”.

2009—Subsec. (a)(2)(E). Pub. L. 111–3, § 201(b)(2)(A), added subpar. (E).

Subsec. (a)(3)(A)(iii). Pub. L. 111–3, § 401(b), added cl. (iii).

Subsec. (a)(3)(D). Pub. L. 111–5, § 4201(a)(1)(A), struck out “and” at end.

Subsec. (a)(3)(E)(ii). Pub. L. 111–5, § 4201(a)(1)(B), substituted “and” for “plus” at end.

Pub. L. 111-3, §211(a)(1)(B)(i), which directed substitution of “and” for “plus” at end and could not be executed, was struck out by Pub. L. 111-148, §2102(a)(8)(A).

Subsec. (a)(3)(F). Pub. L. 111-5, §4201(a)(1)(C), added subpar. (F).

Subsec. (a)(3)(H). Pub. L. 111-3, §211(a)(1)(B), as amended by Pub. L. 111-148, §2102(a)(8)(B), added subpar. (H).

Subsec. (i)(22). Pub. L. 111-3, §211(a)(3)(A), substituted “section 1396a(a)(46)(B) of this title” for “subsection (x)”.

Subsec. (t). Pub. L. 111-5, §4201(a)(2), added subsec. (t).

Subsec. (v)(1). Pub. L. 111-3, §214(a)(1), substituted “paragraphs (2) and (4)” for “paragraph (2)”.

Subsec. (v)(4). Pub. L. 111-3, §214(a)(2), added par. (4).

Subsec. (x)(1). Pub. L. 111-3, §211(a)(3)(B), substituted “section 1396a(a)(46)(B)(i) of this title” for “subsection (i)(22)”.

Subsec. (x)(2)(B), (C). Pub. L. 111-3, §211(b)(4), realigned margins.

Subsec. (x)(2)(D), (E). Pub. L. 111-3, §211(b)(3)(A)(i), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (x)(3)(B)(v), (vi). Pub. L. 111-3, §211(b)(1), added cl. (v) and redesignated former cl. (v) as (vi).

Subsec. (x)(4), (5). Pub. L. 111-3, §211(b)(2), (3)(A)(ii), added pars. (4) and (5).

2008—Subsec. (i)(24). Pub. L. 110-252 added par. (24).

Subsec. (r)(1). Pub. L. 110-379, §3(a)(1), inserted “, in addition to meeting the requirements of paragraph (3),” after “a State must” in introductory provisions.

Subsec. (r)(3). Pub. L. 110-379, §3(a)(2), added par. (3).

2007—Subsec. (i)(23). Pub. L. 110-28 added par. (23).

2006—Subsec. (f)(4). Pub. L. 109-171, §6062(c)(1), inserted “1396a(a)(10)(A)(ii)(XIX),” after “1396a(a)(10)(A)(ii)(XVIII),” in introductory provisions.

Subsec. (i)(10)(C). Pub. L. 109-171, §6002(b), added subpar. (C).

Subsec. (i)(10)(D). Pub. L. 109-171, §6033(a), added subpar. (D).

Subsec. (i)(22). Pub. L. 109-171, §6036(a)(1), added par. (22).

Subsec. (w)(4)(C). Pub. L. 109-432, §403, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (w)(7)(A)(viii). Pub. L. 109-171, §6051(a), amended cl. (viii) generally. Prior to amendment, cl. (viii) read as follows: “Services of a medicaid managed care organization with a contract under subsection (m) of this section.”

Subsec. (x). Pub. L. 109-171, §6036(a)(2), added subsec. (x).

Subsec. (x)(1). Pub. L. 109-432, §405(c)(1)(A)(i), substituted “(i)(22)” for “(i)(23)”.

Subsec. (x)(2). Pub. L. 109-432, §405(c)(1)(A)(ii)(I), substituted “individual declaring to be a citizen or national of the United States” for “alien” in introductory provisions.

Subsec. (x)(2)(B). Pub. L. 109-432, §405(c)(1)(A)(ii)(II), added subpar. (B) and struck out former subpar. (B) which read as follows: “on the basis of receiving supplemental security income benefits under subchapter XVI; or”.

Subsec. (x)(2)(C). Pub. L. 109-432, §405(c)(1)(A)(ii)(V), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 109-432, §405(c)(1)(A)(ii)(III), struck out “other” before “basis” and substituted “has” for “had”.

Subsec. (x)(2)(D). Pub. L. 109-432, §405(c)(1)(A)(ii)(IV), redesignated subpar. (C) as (D).

Subsec. (x)(3)(C)(iii). Pub. L. 109-432, §405(c)(1)(A)(iii), substituted “I-197” for “I-97”.

Subsec. (y). Pub. L. 109-171, §6043(b), added subsec. (y).

Subsec. (z). Pub. L. 109-171, §6081, added subsec. (z).

2005—Subsec. (i)(21). Pub. L. 109-91 added par. (21).

2004—Subsec. (a)(3)(D). Pub. L. 108-357, §712(b)(1), substituted “and” for “plus”.

Subsec. (a)(3)(E). Pub. L. 108-357, §712(b)(2), added subpar. (E).

Subsec. (c). Pub. L. 108-446 substituted “part C” for “part H”.

2000—Subsec. (f)(4). Pub. L. 106-554, §1(a)(6) [title VII, §710(a)], inserted “1396a(a)(10)(A)(ii)(XVIII),” after “1396a(a)(10)(A)(ii)(XVI),”.

Subsec. (m)(2)(A)(ix). Pub. L. 106-554, §1(a)(6) [title VII, §702(c)(1)], repealed Pub. L. 105-33, §4712(c)(2). See 1997 Amendment note below.

Subsec. (u)(1)(D)(v). Pub. L. 106-354 substituted “, for items” for “or for items” and inserted before period at end “, or for medical assistance provided to an individual described in subsection (a) of section 1396r-1b of this title during a presumptive eligibility period under such section”.

1999—Subsec. (a)(3)(C)(i). Pub. L. 106-113, §1000(a)(6) [title VI, §604(a)(2)(B)], struck out “or quality review” after “medical and utilization review”.

Subsec. (b)(4). Pub. L. 106-113, §1000(a)(6) [title VI, §608(e)], inserted “of” after “for the use” in introductory provisions.

Subsec. (d)(3). Pub. L. 106-31, §3031(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (d)(3)(B). Pub. L. 106-113, §1000(a)(6) [title VI, §608(f)], realigned margins.

Subsec. (f)(2). Pub. L. 106-113, §1000(a)(6) [title VI, §608(g)], struck out second period at end.

Subsec. (f)(4). Pub. L. 106-170, §201(b), inserted “1396a(a)(10)(A)(ii)(XV), 1396a(a)(10)(A)(ii)(XVI),” before “1396d(p)(1)” in introductory provisions.

Pub. L. 106-113, §1000(a)(6) [title VI, §608(aa)(2)], substituted “1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV), or 1396d(p)(1) of this title” for “1396d(p)(1), or 1396d(u) of this title” in introductory provisions.

Subsec. (i)(14). Pub. L. 106-113, §1000(a)(6) [title VI, §608(h)], inserted “or” after semicolon.

Subsec. (i)(19). Pub. L. 106-31, §3031(b), added par. (19).

Subsec. (i)(20). Pub. L. 106-170, §201(a)(4), added par. (20).

Subsec. (m)(2)(A)(vi). Pub. L. 106-113, §1000(a)(6) [title VI, §608(i)(1)], struck out semicolon after “section 1396u-2(a)(4) of this title”.

Subsec. (m)(2)(A)(xi), (xii). Pub. L. 106-113, §1000(a)(6) [title VI, §608(i)(2)], redesignated cl. (xi), relating to section 1396u-2, as (xii).

Subsec. (m)(6)(B)(ii). Pub. L. 106-113, §1000(a)(6) [title VI, §604(b)(2)(A)], inserted “and” at end.

Subsec. (m)(6)(B)(iii). Pub. L. 106-113, §1000(a)(6) [title VI, §604(b)(2)(B)], substituted a period for “; and” at end.

Subsec. (m)(6)(B)(iv). Pub. L. 106-113, §1000(a)(6) [title VI, §604(b)(2)(C)], struck out cl. (iv) which read as follows: “that the State agency will contract, for purposes of meeting the requirement under section 1396a(a)(30)(C) of this title, with an organization or entity that under section 1320c-3 of this title reviews services provided by an eligible organization pursuant to a contract under section 1395mm of this title for the purpose of determining whether the quality of services meets professionally recognized standards of health care.”

Subsec. (o). Pub. L. 106-113, §1000(a)(6) [title VI, §608(j)], struck out second closing parenthesis after “section 1167(1) of title 29”.

Subsec. (q)(3). Pub. L. 106-170, §407(a), inserted “(A)” after “in connection with” and added subpar. (B).

Subsec. (q)(4). Pub. L. 106-170, §407(c), amended par. (4) generally. Prior to amendment, par. (4) read as follows: “The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this subchapter, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.”

Subsec. (q)(5). Pub. L. 106-170, §407(b), inserted “or under any Federal health care program (as so defined)” before “to health care facilities” and inserted at end “All funds collected in accordance with this paragraph

shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection.”

Subsec. (w)(1)(B). Pub. L. 106-113, §1000(a)(6) [title VI, §608(k)(1)], substituted “purposes” for “puroses”.

Subsec. (w)(3)(B). Pub. L. 106-113, §1000(a)(6) [title VI, §608(k)(2)], inserted a comma after “(D)” in introductory provisions.

Subsec. (w)(7)(A)(viii). Pub. L. 106-113, §1000(a)(6) [title VI, §608(k)(3)], realigned margins.

1997—Subsec. (a)(3)(C). Pub. L. 105-33, §4705(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4). Pub. L. 105-33, §4707(b), added par. (4).

Subsec. (b)(5). Pub. L. 105-33, §4722(b), added par. (5).

Subsec. (f)(4). Pub. L. 105-100 substituted “1396d(p)(1), or 1396d(u) of this title” for “or 1396d(p)(1) of this title” in introductory provisions.

Subsec. (f)(4)(C). Pub. L. 105-33, §4802(b)(2), inserted “or who is a PACE program eligible individual enrolled in a PACE program under section 1396u-4 of this title,” after “section 1396a(a)(10)(A) of this title.”

Subsec. (i). Pub. L. 105-33, §4708(d), inserted at end of closing provisions “Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1396u-2(a)(1)(B) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.”

Subsec. (i)(2). Pub. L. 105-33, §4724(a)(1), substituted “; or” for the period at end.

Subsec. (i)(10)(B), (11). Pub. L. 105-33, §4724(a)(2), inserted “or” at end.

Subsec. (i)(12). Pub. L. 105-33, §4742(a), struck out par. (12) which related to restrictions on payments, on or after Jan. 1, 1992, for physicians’ services to children under 21 years of age and to pregnant women.

Subsec. (i)(13). Pub. L. 105-33, §4724(a)(2), inserted “or” at end.

Subsec. (i)(16). Pub. L. 105-12 added par. (16).

Subsec. (i)(17). Pub. L. 105-33, §4724(a)(1), (3), added par. (17).

Subsec. (i)(18). Pub. L. 105-33, §4724(b)(1), added par. (18).

Subsec. (k). Pub. L. 105-33, §4701(b)(2)(A)(v), substituted “medicaid managed care organization” for “health maintenance organization”.

Subsec. (m)(1)(A). Pub. L. 105-33, §4701(b)(1), in introductory provisions, substituted “The term ‘medicaid managed care organization’ means a health maintenance organization, an eligible organization with a contract under section 1395mm of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1396a(w) of this title and—” for “The term ‘health maintenance organization’ means a public or private organization, organized under the laws of any State, which meets the requirement of section 1396a(w) of this title is a qualified health maintenance organization (as defined in section 300e-9(d) of this title) or which meets the requirement of section 1396a(a) of this title and—” and inserted as closing provisions “An organization that is a qualified health maintenance organization (as defined in section 300e-9(d) of this title) is deemed to meet the requirements of clauses (i) and (ii).”

Subsec. (m)(1)(A)(ii). Pub. L. 105-33, §4706(1), inserted “, meets the requirements of subparagraph (C)(i) (if applicable),” after “provision is satisfactory to the State”.

Subsec. (m)(1)(B). Pub. L. 105-33, §4701(b)(2)(A)(vi), substituted “medicaid managed care organization” for “health maintenance organization”.

Subsec. (m)(1)(C). Pub. L. 105-33, §4706(2), added subpar. (C).

Subsec. (m)(2)(A)(i). Pub. L. 105-33, §4701(b)(2)(A)(vii), substituted “medicaid managed care organization” for “health maintenance organization”.

Subsec. (m)(2)(A)(ii). Pub. L. 105-33, §4703(a), struck out cl. (ii) which read as follows: “less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter;”.

Subsec. (m)(2)(A)(iii). Pub. L. 105-33, §4708(a), substituted “\$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year” for “\$100,000”.

Subsec. (m)(2)(A)(vi). Pub. L. 105-33, §4701(d)(2)(A), struck out “except as provided under subparagraph (F),” after “such contract (I),” substituted “in accordance with section 1396u-2(a)(4) of this title;” for “without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination”, and inserted “in accordance with such section” after “provides for notification”.

Subsec. (m)(2)(A)(ix). Pub. L. 105-33, §4712(c)(2), which directed the repeal of subsec. (m)(2)(A)(ix), was repealed by Pub. L. 106-554, §1(a)(6) [title VII, §702(c)(1)]. See 2000 Amendment note above and Effective Date of 1997 Amendment note below.

Pub. L. 105-33, §4712(b)(2), amended cl. (ix) generally. Prior to amendment, cl. (ix) read as follows: “such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1396a(a)(13)(E) of this title, and (II) at the election of such center payments made by the entity to such a center for services described in 1396d(a)(2)(C) of this title are made at the rates of payment specified in section 1396a(a)(13)(E) of this title;”.

Subsec. (m)(2)(A)(xi). Pub. L. 105-33, §4701(c), added cl. (xi) relating to section 1396u-2.

Subsec. (m)(2)(C) to (E). Pub. L. 105-33, §4703(b)(1)(A), struck out subpars. (C) to (E) which read as follows:

“(C) Subparagraph (A)(ii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

“(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.

“(E) In the case of a health maintenance organization that—

“(i) is a nonprofit organization with at least 25,000 members,

“(ii) is and has been a qualified health maintenance organization (as defined in section 300e-9(d) of this title) for a period of at least four years,

“(iii) provides basic health services through members of the staff of the organization,

“(iv) is located in an area designated as medically underserved under section 300e-1(7) of this title, and

“(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1315 of this title,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Sec-

retary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter."

Subsec. (m)(2)(F). Pub. L. 105-33, § 4701(d)(2)(B), struck out subpar. (F) which read as follows: "In the case of—

"(i) a contract with an entity described in subparagraph (E) or (G), with a qualified health maintenance organization (as defined in section 300e-9(d) of this title) which meets the requirement of subparagraph (A)(ii), or or with an eligible organization with a contract under section 1395mm of this title which meets the requirement of subparagraph (A)(ii), or

"(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of subchapter XVIII of this chapter or eligible for benefits under this subchapter, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause."

Subsec. (m)(2)(G). Pub. L. 105-33, § 4703(b)(1)(B), substituted "clause (i)" for "clauses (i) and (ii)".

Subsec. (m)(2)(H). Pub. L. 105-33, § 4702(b)(1)(B), in concluding provisions, inserted before period at end "or with the manager described in such clause if the manager continues to have a contract described in section 1396d(t)(3) of this title with the State".

Pub. L. 105-33, § 4701(b)(2)(B), struck out "health maintenance" before "organization described" in concluding provisions.

Subsec. (m)(2)(H)(i). Pub. L. 105-33, § 4702(b)(1)(A), inserted "or with a primary care case manager with a contract described in section 1396d(t)(3) of this title" before comma at end.

Pub. L. 105-33, § 4701(b)(2)(A)(vii), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (m)(4)(A). Pub. L. 105-33, § 4701(b)(2)(A)(viii), substituted "Each medicaid managed care organization" for "Each health maintenance organization".

Subsec. (r)(1). Pub. L. 105-33, § 4753(a)(1), added par. (1) and struck out former par. (1) which read as follows:

"(1)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) of this section without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) of this section and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

"(B) The deadline for operation of such systems for a State is September 30, 1985.

"(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary

determines the State fails to meet the requirements of subparagraph (A); except that—

"(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

"(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A)."

Subsec. (r)(2). Pub. L. 105-33, § 4753(a)(1), (2)(B), (D), inserted introductory provisions, redesignated par. (5)(A)(i) to (iii) as par. (2)(A) to (C), and struck out former par. (2) which read as follows:

"(2)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) of this section without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

"(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

"(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

"(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

"(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

"(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) of this section on or before October 7, 1980, shall be deemed to be initially approved for purposes of this subsection."

Subsec. (r)(3), (4). Pub. L. 105-33, § 4753(a)(1), struck out pars. (3) and (4) which related to Federal matching funds and Secretary's periodic review of approved retrieval systems.

Subsec. (r)(5). Pub. L. 105-33, § 4753(a)(2), struck out introductory provisions relating to requirements for Secretary's initial approval of mechanized claims processing and information retrieval systems and struck out "under paragraph (6)" before period at end of subpar. (A)(iii), redesignated subpar. (A)(i) to (iii) as par. (2)(A) to (C), and struck out subpar. (B) which related to requirements for Secretary's reappraisal of mechanized claims processing and information retrieval systems.

Subsec. (r)(6) to (8). Pub. L. 105-33, § 4753(a)(3), struck out pars. (6) to (8) which related to Secretary's development of performance standards for approval of State mechanized processing claims and information retrieval systems, waiver of certain requirements for initial operation, and applicability of per centum reductions in certain situations.

Subsec. (u)(1)(D)(v). Pub. L. 105-33, § 4912(b)(2), inserted before period at end "or for items and services described in subsection (a) of section 1396r-1a of this title provided to a child during a presumptive eligibility period under such section".

Subsec. (w)(3)(B). Pub. L. 105-33, § 4722(a)(1), substituted "(E), and (F)" for "and (E)" in introductory provisions.

Subsec. (w)(3)(F). Pub. L. 105-33, § 4722(a)(2), added subpar. (F).

Subsec. (w)(7)(A)(viii). Pub. L. 105-33, § 4701(b)(2)(C), amended cl. (viii) generally. Prior to amendment, cl.

(viii) read as follows: “Services of health maintenance organizations (and other organizations with contracts under subsection (m) of this section).”

1996—Subsec. (i)(9). Pub. L. 104-193 struck out par. (9) which read as follows: “with respect to any amount of medical assistance for pregnant women and children described in section 1396a(a)(10)(A)(i)(IX) of this title, if the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are less than the payment levels in effect under such plan on July 1, 1987;”.

Subsec. (i)(12)(A)(i). Pub. L. 104-248, §1(b)(1)(A), inserted “or is certified in family practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association” before comma at end.

Subsec. (i)(12)(A)(vi). Pub. L. 104-248, §1(b)(1)(C)(i), (iii), (iv), added cl. (vi) and redesignated former cl. (vi) as (vii).

Pub. L. 104-248, §1(b)(1)(C)(ii), inserted “(or certified by the State in accordance with policies of the Secretary)” after “Secretary”.

Subsec. (i)(12)(A)(vii). Pub. L. 104-248, §1(b)(1)(C)(iii), redesignated cl. (vi) as (vii).

Subsec. (i)(12)(B)(i). Pub. L. 104-248, §1(b)(1)(B), inserted “or is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association” before comma at end.

Subsec. (i)(12)(B)(vi). Pub. L. 104-248, §1(b)(1)(C)(i), (iii), (iv), added cl. (vi) and redesignated former cl. (vi) as (vii).

Pub. L. 104-248, §1(b)(1)(C)(ii), inserted “(or certified by the State in accordance with policies of the Secretary)” after “Secretary”.

Subsec. (i)(12)(B)(vii). Pub. L. 104-248, §1(b)(1)(C)(iii), redesignated cl. (vi) as (vii).

1993—Subsec. (i)(10). Pub. L. 103-66, §13631(c)(1), which directed the amendment of par. (10) by striking all that follows “1396r-8(g) of this title” and inserting a semicolon, could not be executed because “1396r-8(g) of this title” did not appear subsequent to the general amendment of par. (10) by Pub. L. 103-66, §13602(b). See below.

Pub. L. 103-66, §13602(b), amended par. (10) generally. Prior to amendment, par. (10) read as follows: “with respect to covered outpatient drugs of a manufacturer dispensed in any State unless, (A) except as provided in section 1396r-8(a)(3) of this title, the manufacturer complies with the rebate requirements of section 1396r-8(a) of this title with respect to the drugs so dispensed in all States, and (B) effective January 1, 1993, the State provides for drug use review in accordance with section 1396r-8(g) of this title; or”.

Subsec. (i)(11). Pub. L. 103-66, §13631(c)(2), redesignated par. (12) as (11), transferred such par. to appear after par. (10), and substituted semicolon for period at end. Former par. (11) redesignated (13).

Subsec. (i)(12). Pub. L. 103-66, §13631(c)(3), redesignated par. (14) as (12), transferred such par. to appear after par. (11), as redesignated by Pub. L. 103-66, §13631(c)(2), and substituted semicolon for period at end. Former par. (12) redesignated (11).

Subsec. (i)(13). Pub. L. 103-66, §13631(c)(4), redesignated par. (11) as (13), transferred such par. to appear after par. (12), as redesignated by Pub. L. 103-66, §13631(c)(3), and directed substitution of “; or” for period at end.

Subsec. (i)(14). Pub. L. 103-66, §13631(c)(5), added par. (14).

Subsec. (i)(15). Pub. L. 103-66, §13631(h)(1), added par. (15).

Subsec. (o). Pub. L. 103-66, §13622(a)(2), substituted “regulation and including a group health plan (as defined in section 1167(1) of title 29), a service benefit plan, and a health maintenance organization)” for “regulation”.

Subsec. (s). Pub. L. 103-66, §13624(a), added subsec. (s).
Subsec. (v)(2)(C). Pub. L. 103-66, §13604(a), added subpar. (C).

1991—Subsec. (a)(1). Pub. L. 102-234, §3(b)(2)(B), inserted “and section 1396r-4(f) of this title” after “of this section”.

Subsec. (c). Pub. L. 102-119 substituted “child with a disability” for “handicapped child”, “Individuals with Disabilities Education Act” for “Education of the Handicapped Act”, and “an infant or toddler with a disability” for “a handicapped infant or toddler”.

Subsec. (d)(6). Pub. L. 102-234, §4(a), added par. (6).

Subsec. (i)(10). Pub. L. 102-234, §2(b)(2), struck out par. (10) added by Pub. L. 101-508, §4701(b)(2)(B), which read as follows: “with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State solely [sic] with respect to hospitals or facilities.”

Subsec. (w). Pub. L. 102-234, §2(a), added subsec. (w).

1990—Subsec. (a)(1). Pub. L. 101-508, §4402(d)(3), struck out before semicolon “(including expenditures for medicare cost-sharing and including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof)”.

Subsec. (a)(2)(B). Pub. L. 101-508, §4801(a)(8), substituted “October 1, 1990” for “July 1, 1990”.

Subsec. (a)(3)(C), (D). Pub. L. 101-508, §4401(b)(1), substituted “and” for “plus” at end of subpar. (C) and added subpar. (D).

Subsec. (f)(2). Pub. L. 101-508, §4723(a), inserted “(A)” after “(2)” and added cl. (B).

Subsec. (f)(4). Pub. L. 101-508, §4601(a)(3)(A), substituted “1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII)” for “1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(VI)”.

Subsec. (i)(8). Pub. L. 101-508, §4711(c)(2), inserted “(A)” after “medical assistance” and added cl. (B).

Subsec. (i)(10). Pub. L. 101-508, §4701(b)(2), added par. (10) relating to any amount expended for medical assistance for care or services.

Pub. L. 101-508, §4401(a)(1), added par. (10) relating to covered outpatient drugs.

Subsec. (i)(11). Pub. L. 101-508, §4801(e)(16)(A), added par. (11).

Subsec. (i)(12). Pub. L. 101-508, §4752(a)(2), added par. (12).

Subsec. (i)(14). Pub. L. 101-508, §4752(e), added par. (14).

Subsec. (m)(1)(A). Pub. L. 101-508, §4751(b)(1), inserted “meets the requirement of section 1396a(w) of this title” after “State, which” and “meets the requirement of section 1396a(a) of this title and” after “or which”.

Subsec. (m)(2)(A)(i). Pub. L. 101-508, §4732(d)(1), struck out “(or the State as authorized by paragraph (3))” after “the Secretary”.

Subsec. (m)(2)(A)(ix). Pub. L. 101-508, §4704(b)(1), added cl. (ix).

Subsec. (m)(2)(A)(x). Pub. L. 101-508, §4731(a), added cl. (x).

Subsec. (m)(2)(A)(xi). Pub. L. 101-508, §4752(b)(1), added cl. (xi).

Subsec. (m)(2)(B). Pub. L. 101-508, §4704(b)(2), inserted “except with respect to clause (ix) of subparagraph (A),” after “Subparagraph (A)”.

Subsec. (m)(2)(D). Pub. L. 101-508, §4732(a), struck out “(i) special circumstances warrant such modification

or waiver, and (ii)” after “the Secretary determines that”.

Subsec. (m)(2)(F)(i). Pub. L. 101-508, §4732(b)(2), substituted “(G),” for “(G) or” and inserted at end “or with an eligible organization with a contract under section 1395mm of this title which meets the requirement of subparagraph (A)(ii), or”.

Subsec. (m)(2)(H). Pub. L. 101-508, §4732(c), added subpar. (H).

Subsec. (m)(3). Pub. L. 101-508, §4732(d)(2), struck out par. (3) which read as follows: “A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this subchapter that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity’s qualification under paragraph (1).”

Subsec. (m)(5)(A)(v). Pub. L. 101-508, §4731(b)(2), added cl. (v).

Subsec. (u)(1)(D)(iv). Pub. L. 101-508, §4402(b), which directed amendment of subpar. (C)(iv) by inserting before period at end “or with respect to payments made in violation of section 1396e of this title”, was executed to subpar. (D)(iv) to reflect the probable intent of Congress because subpar. (C) does not have a cl. (iv).

1989—Subsec. (a)(2)(B). Pub. L. 101-239, §6901(b)(5)(A), inserted “(including the costs for nurse aides to complete such competency evaluation programs)” after “1396r(e)(1) of this title” and “(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)” after “50 percent”.

Subsec. (f)(4). Pub. L. 101-239, §6401(b), inserted “1396a(a)(10)(A)(i)(VI),” after “1396a(a)(10)(A)(i)(IV).”

Subsec. (i)(2). Pub. L. 101-239, §6411(d)(2), inserted “, not including items or services furnished in an emergency room of a hospital” after “emergency item or service”.

Subsec. (i)(5). Pub. L. 101-234 repealed Pub. L. 100-360, §202(h)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a)(1). Pub. L. 100-360, §301(f), amended Pub. L. 99-509, §9403(g)(2), see 1986 Amendment note below.

Subsec. (c). Pub. L. 100-360, §411(k)(13)(A), added subsec. (c).

Subsec. (f)(2). Pub. L. 100-360, §411(k)(10)(G)(ii), amended Pub. L. 100-203, §4118(h)(1), see 1987 Amendment note below.

Subsec. (f)(4). Pub. L. 100-360, §302(e)(4), inserted “1396a(a)(10)(A)(i)(IV),” before “1396a(a)(10)(A)(i)(IX)” in introductory provisions.

Subsec. (i)(2)(A). Pub. L. 100-360, §411(k)(10)(D), as amended by Pub. L. 100-485, §608(d)(26)(K)(ii), added Pub. L. 100-203, §4118(e)(11)(A), see 1987 Amendment note below.

Subsec. (i)(2)(B). Pub. L. 100-360, §411(k)(10)(D), as amended by Pub. L. 100-485, §608(d)(26)(K)(ii), added Pub. L. 100-203, §4118(e)(11)(B), see 1987 Amendment note below.

Subsec. (i)(3). Pub. L. 100-360, §411(k)(6)(B)(x), added Pub. L. 100-203, §4112(b), see 1987 Amendment note below.

Subsec. (i)(5). Pub. L. 100-360, §202(h)(2), substituted “section 1395y(c)(1)” for “section 1395y(c)”.

Subsec. (i)(9). Pub. L. 100-360, §302(c)(3), added par. (9).

Subsec. (m)(2)(B)(i)(II). Pub. L. 100-485, §608(f)(4), substituted “1396a(a)(10)(D) of this title” for “1396a(a)(13)(A)(ii) of this title”.

Subsec. (m)(2)(F). Pub. L. 100-360, §411(k)(7)(D), repealed Pub. L. 100-203, §4113(d)(1), see 1987 Amendment note below.

Pub. L. 100-360, §411(a)(3)(A), (B)(iii), (k)(7)(A), amended Pub. L. 100-203, §4113(a)(1)(B), see 1987 Amendment note below.

Subsec. (m)(5). Pub. L. 100-360, §411(k)(12)(A), amended par. (5) generally. Prior to amendment, par. (5) read as follows:

“(A) Any entity with a contract under this subsection that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than \$10,000 for each such failure.

“(B) The provisions of section 1320a-7a of this title (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.”

1987—Subsec. (a)(1). Pub. L. 100-203, §4211(g)(2), substituted “and (j)” for “, (h), and (j)”.

Subsec. (a)(2)(A) to (C). Pub. L. 100-203, §4211(d)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (a)(2)(D). Pub. L. 100-203, §4212(c)(1), added subpar. (D).

Subsec. (a)(3)(C). Pub. L. 100-203, §4113(b)(3), inserted “or by an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary,” after “organization”.

Subsec. (a)(7). Pub. L. 100-203, §4212(e)(2), inserted “subject to section 1396r(g)(3)(B) of this title,” after “(7)”.

Subsec. (f)(2). Pub. L. 100-203, §4118(h)(1), as amended by Pub. L. 100-360, §411(k)(10)(G)(ii), substituted “(whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof)” for “(whether in the form of insurance premiums or otherwise)”.

Subsec. (f)(4). Pub. L. 100-203, §4118(p)(5), inserted “, 1396a(a)(10)(A)(ii)(X), or 1396d(p)(1)” after “1396a(a)(10)(A)(ii)(IX)”.

Subsec. (g)(1). Pub. L. 100-203, §4212(d)(1)(A), substituted “or services in an intermediate care facility for the mentally retarded” for first reference to “or intermediate care facility services”, struck out “, skilled nursing facility services for 30 days,” after first reference to “60 days”, substituted “or services in an intermediate care facility for the mentally retarded” for “, skilled nursing facility services, or intermediate care facility services”, and substituted “and intermediate care facilities for the mentally retarded” for “, skilled nursing facilities, and intermediate care facilities”.

Subsec. (g)(4)(B). Pub. L. 100-203, §4212(d)(1)(B), substituted “and intermediate care facilities for the mentally retarded” for “, skilled nursing facilities, and intermediate care facilities”.

Subsec. (g)(6)(B) to (D). Pub. L. 100-203, §4212(d)(1)(C), redesignated subpar. (C) as (B) and substituted “services in an intermediate care facility for the mentally retarded” for “intermediate care facility services”, redesignated subpar. (D) as (C), and struck out former subpar. (B) which read as follows: “Such recertifications in the case of skilled nursing facility services shall be conducted at least—

“(i) 30 days after the date of the initial certification,

“(ii) 60 days after the date of the initial certification,

“(iii) 90 days after the date of the initial certification, and

“(iv) every 60 days thereafter.”

Subsec. (g)(7). Pub. L. 100-203, §4212(d)(1)(D), struck out par. (7) which read as follows: “It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this subchapter, and the enforcement of

such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.”

Subsec. (h). Pub. L. 100-203, § 4211(g)(1), struck out subsec. (h) which related to reduction by Secretary of amount otherwise considered as expenditures under State plan where reasonable cost differential between statewide average cost of skilled nursing facility services and statewide average cost of intermediate care facility services does not exist for any calendar quarter beginning after June 30, 1973.

Subsec. (i). Pub. L. 100-203, § 4118(d)(1)(B), inserted sentence at end that nothing in par. (1) be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose.

Subsec. (i)(1). Pub. L. 100-203, § 4118(d)(1)(A), substituted “; or” for period at end.

Subsec. (i)(2). Pub. L. 100-93, § 8(g), amended par. (2) generally. Prior to amendment, par. (2) read as follows: “with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under subchapter XVIII of this chapter with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1395y(d)(1) of this title or under clause (D), (E), or (F) of section 1395cc(b)(2) of this title, or by reason of non-compliance with a request made by the Secretary under clause (C)(ii) of such section 1395cc(b)(2) or under section 1396a(a)(38) of this title; or”.

Subsec. (i)(2)(A). Pub. L. 100-203, § 4118(e)(11)(A), as added by Pub. L. 100-360, § 411(k)(10)(D), as amended by Pub. L. 100-485, § 608(d)(26)(K)(ii), substituted “under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title” for “in the State plan under this subchapter pursuant to section 1320a-7 of this title or section 1320a-7a of this title”.

Subsec. (i)(2)(B). Pub. L. 100-203, § 4118(e)(11)(B), as added by Pub. L. 100-360, § 411(k)(10)(D), as amended by Pub. L. 100-485, § 608(d)(26)(K)(ii), substituted “from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title” for “pursuant to section 1320a-7 of this title or section 1320a-7a of this title from participation in the program under this subchapter”.

Subsec. (i)(3). Pub. L. 100-203, § 4112(b), as added by Pub. L. 100-360, § 411(k)(6)(B)(x), inserted “(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)” before “to the extent”.

Subsec. (i)(4). Pub. L. 100-203, § 4211(i), struck out “or skilled nursing facility” after “hospital” in three places.

Subsec. (i)(8). Pub. L. 100-203, § 4213(b)(2), added par. (8).

Subsec. (m)(2)(F). Pub. L. 100-203, § 4113(d)(1), which directed the substitution of “subparagraphs (E) or (G)” for “subparagraph (G)”, was repealed by Pub. L. 100-360, § 411(k)(7)(D).

Pub. L. 100-203, § 4113(a)(1)(B), as amended by Pub. L. 100-360, § 411(a)(3)(A), (B)(iii), (k)(7)(A), substituted “(F) In the case of—” and cls. (i) and (ii) for “(F) In the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 300e-9(d) of this title) which meets the requirement of subparagraph (A)(ii),”.

Subsec. (m)(6). Pub. L. 100-203, § 4113(a)(1)(A), added par. (6).

Subsec. (n). Pub. L. 100-93, § 8(h)(1), struck out subsec. (n) which related to State agency action upon disclosure or failure to disclose required information by institution, organization, etc.

Subsec. (r). Pub. L. 100-203, § 4212(c)(2), substituted “paragraphs 2(A)” for “paragraphs 2)” in pars. (1)(A), (C) and (2)(A), (C).

1986—Subsec. (a)(1). Pub. L. 99-509, § 9403(g)(2), as amended by Pub. L. 100-360, § 301(f), inserted “including expenditures for medicare cost-sharing and” before “including expenditures”.

Subsec. (a)(3)(C). Pub. L. 99-509, § 9431(b)(2), inserted “or quality review” after “medical and utilization review”.

Subsec. (a)(4). Pub. L. 99-603 added par. (4).

Subsec. (d)(2). Pub. L. 99-272, § 9512(a), designated first sentence as subpar. (A), designated second sentence as subpar. (B), properly indented and aligned below subpar. (A), and added subpars. (C) and (D).

Subsec. (f)(4). Pub. L. 99-509, § 9401(e)(2), inserted “for any individual described in section 1396a(a)(10)(A)(ii)(IX) of this title or” after “as medical assistance”.

Subsec. (i)(1). Pub. L. 99-272, § 9507(a), added par. (1).

Subsec. (m)(2)(A). Pub. L. 99-272, § 9517(a)(1), substituted “subparagraphs (B), (C), and (G)” for “subparagraphs (B) and (C)” in introductory text.

Pub. L. 99-272, § 9517(c)(1), inserted “(including a health insuring organization)” after “any entity” and “(directly or through arrangements with providers of services)” after “responsible for the provision” in introductory text.

Subsec. (m)(2)(A)(iii). Pub. L. 99-509, § 9434(a)(2), inserted before the semicolon “and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$100,000”.

Subsec. (m)(2)(A)(viii). Pub. L. 99-509, § 9434(a)(1)(A), added cl. (viii).

Subsec. (m)(2)(F). Pub. L. 99-514, § 1895(c)(2), substituted “In the case” for “in the case”.

Pub. L. 99-272, § 9517(a)(2), struck out designation “(i)” at beginning of subpar. (F), substituted “in the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 300e-9(d) of this title) which meets the requirement of subparagraph (A)(ii)” for “In the case of a contract with a health maintenance organization described in clause (ii)”, substituted “such entity or organization” for “such organization”, and struck out cl. (ii) which defined a health maintenance organization.

Subsec. (m)(2)(G). Pub. L. 99-272, § 9517(a)(3), added subpar. (G).

Subsec. (m)(4). Pub. L. 99-509, § 9434(a)(1)(B), added par. (4).

Subsec. (m)(5). Pub. L. 99-509, § 9434(b), added par. (5).

Subsec. (r)(1)(B). Pub. L. 99-272, § 9518(a), substituted “September 30, 1985” for “the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State’s most recently approved advance planning document submitted before October 7, 1980”.

Subsec. (r)(4)(A). Pub. L. 99-272, § 9503(b)(2), substituted “once every three years” for “once each fiscal year” and inserted at end “Reviews may, at the Secretary’s discretion, constitute reviews of the entire system or of only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews.”

Subsec. (r)(6)(J). Pub. L. 99-272, § 9503(b)(1), amended subpar. (J) generally. Prior to amendment, subsec. (J) read as follows: “report on or before October 1, 1981, to the Congress on the extent to which States have developed and operated effective mechanized claims processing and information retrieval systems.”

Subsec. (u)(1)(D)(iv). Pub. L. 99-272, § 9503(f), added cl. (iv).

Subsec. (u)(1)(D)(v). Pub. L. 99-509, § 9407(c), added cl. (v).

Subsec. (v). Pub. L. 99-509, § 9406(a), added subsec. (v).

1984—Subsec. (g)(1). Pub. L. 98-369, § 2363(a)(2)(A), (B), in provision preceding subpar. (A), substituted “inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for” for “care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or in-

intermediate care facility on 60 days, or in a hospital for mental diseases on", and struck out "which for purposes of this section means the four calendar quarters ending with June 30," before "the Federal medical assistance percentage", and struck out "in the same fiscal year" before "shall be decreased by a per centum thereof".

Pub. L. 98-369, §2363(a)(2)(C), substituted "skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams" for "(including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—" and former subpars. (A) through (D) requirement for evidence concerning an effective program of utilization of certain medical services.

Subsec. (g)(4)(B). Pub. L. 98-369, §2373(b)(11), substituted "paragraphs (26)" for "paragraph (26)" and "diligence" for "deligence".

Subsec. (g)(6). Pub. L. 98-369, §2363(a)(4), in amending par. (6) generally, substituted provisions relating to recertifications for provisions relating to reports to Congress concerning Secretary's determination and review of showing respecting any decrease of Federal medical assistance percentage of amounts paid for services.

Subsec. (g)(7). Pub. L. 98-369, §2363(b), as amended by Pub. L. 98-617, §3(a)(6), added par. (7).

Subsec. (i)(7). Pub. L. 98-369, §2303(g)(2), added par. (7).

Subsec. (m)(2)(A)(vi). Pub. L. 98-369, §2364(1), inserted "except as provided under subparagraph (F)," after "(I)".

Subsec. (m)(2)(B)(i)(I). Pub. L. 98-369, §2373(b)(12)(A), (C), struck out "(II)" before "for the period" and substituted "period" for "peroid".

Subsec. (m)(2)(B)(i)(II). Pub. L. 98-369, §2373(b)(12)(B), substituted "of section 1396d(a) of this title" for "of such section".

Subsec. (m)(2)(C). Pub. L. 98-369, §2373(b)(13), realigned margin of subpar. (C).

Subsec. (m)(2)(E), (F). Pub. L. 98-369, §2364(2), added subpars. (E) and (F).

Subsec. (s)(3)(B). Pub. L. 98-369, §2373(b)(14), substituted "non-Federal" for "nonfederal".

1983—Subsec. (t)(3). Pub. L. 97-448 substituted "purposes" for "purpose" and "the lower of the Federal medical assistance percentage for the State in effect for fiscal year 1981, or the Federal medical assistance percentage for the State in effect for fiscal year 1982" for "the Federal medical assistance percentage for States in effect for fiscal year 1981, disregarding any change in such percentage after fiscal year 1981".

1982—Subsec. (a)(3)(C). Pub. L. 97-248, §146(b), substituted "utilization and quality control peer review organization" for "Professional Standards Review Organization".

Subsec. (f)(3). Pub. L. 97-248, §137(g), struck out "(without regard to section 608 of this title)" after "consisting of one person if such plan".

Subsec. (g)(1). Pub. L. 97-248, §137(b)(11), inserted "or which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title)".

Subsec. (g)(1)(A). Pub. L. 97-248, §137(b)(12), substituted "provided in an institution for the mentally retarded" for "described in section 1396d(d) of this title".

Subsec. (k). Pub. L. 97-248, §137(b)(13), substituted "subsection (m) of this section" for "section 1395mm of this title".

Subsec. (m)(2)(A). Pub. L. 97-248, §137(b)(14), substituted "or" for "and" before "(II)" in cl. (iv), and substituted "unforeseen" for "unforseen" in cl. (vii)(II).

Subsec. (s). Pub. L. 97-248, §137(a)(2), amended directory language of Pub. L. 97-35, §2161(c)(1), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (s)(1)(A). Pub. L. 97-248, §137(b)(15)(A), (B), in provisions following cl. (iii), substituted "fiscal year 1982" for "fiscal year 1981", and "subsections (a)(6) and (t) of this section, without regard to payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service," for "subsection (t) of this section".

Subsec. (s)(1)(C). Pub. L. 97-248, §137(b)(15)(C), inserted "a program in operation under", before "a plan approved".

Subsec. (s)(3)(D). Pub. L. 97-248, §137(b)(15)(D), substituted "must determine that" for "determines that", "most recent year (which shall consist of a 12-month period determined by the Secretary for this purpose)" for "most recent calendar year", and "2- or 3-year period" for "2 or 3 calendar year period", and struck out "calendar" wherever appearing.

Subsec. (s)(4)(B). Pub. L. 97-248, §137(b)(15)(E), inserted "and paragraph (3)(D)".

Subsec. (s)(5)(A)(i). Pub. L. 97-248, §137(b)(15)(F), inserted "(including amounts saved, to the extent such amounts can be documented to the satisfaction of the Secretary, by reason of the suspension or termination of a provider or other person for fraud or abuse, but only during the period of such suspension or termination or, if shorter, the 1-year period beginning on the date of such termination or suspension)" after "recovered or diverted".

Subsec. (s)(5)(B). Pub. L. 97-248, §137(b)(27), inserted "or quarters" after "carried forward to the following quarter".

Subsec. (t). Pub. L. 97-248, §137(a)(1), (2), amended directory language of Pub. L. 97-35, §2161(b), (c)(2), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (t)(1)(A). Pub. L. 97-248, §137(b)(16)(A), substituted "payments under subsection (a)(6) of this section, interest paid under subsection (d)(5) of this section, and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service" for "interest paid under subsection (d)(5) of this section".

Subsec. (t)(1)(B). Pub. L. 97-248, §137(b)(16)(B), (D), substituted "Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics" for "consumer price index for all urban consumers (published by the Bureau of Labor Statistics)" and "for the 12-month period ending on September 30, 1983" for "between September 1982 and September 1983".

Subsec. (t)(1)(C). Pub. L. 97-248, §137(b)(16)(C), (D), substituted "Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics" for "consumer price index for all urban consumers (published by the Bureau of Labor Statistics)" and "for the 24-month period ending on September 30, 1984" for "between September 1982 and September 1984".

Subsec. (t)(2)(A). Pub. L. 97-248, §137(b)(16)(A), substituted "payments under subsection (a)(6) of this section, interest paid under subsection (d)(5) of this section, and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service" for "interest paid under subsection (d)(5) of this section".

Subsec. (t)(3). Pub. L. 97-248, §137(b)(16)(E), substituted "for fiscal years 1982, 1983, and 1984" for "for fiscal year 1984" wherever appearing, "years 1983, 1984, and 1985, respectively" for "year 1985", "in effect for fiscal year 1981" for "in effect for fiscal year 1983", and "after fiscal year 1981" for "between fiscal year 1983 and fiscal year 1984".

Subsec. (u). Pub. L. 97-248, §133(a), added subsec. (u). 1981—Subsec. (a)(3)(B). Pub. L. 97-35, §2113(n), substituted “and” for “plus” at the end of subpar. (B) and added subpar. (C).

Subsec. (d)(5). Pub. L. 97-35, §2163, substituted “determination at a rate” for “determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at a rate”.

Subsec. (e). Pub. L. 97-35, §2101(a)(2), added subsec. (e).

Subsec. (g)(1)(A). Pub. L. 97-35, §2183(a), inserted “and the physician, or a physician assistant or nurse practitioner under the supervision of a physician” and “or, in the case of services that are intermediate care facility services described in section 1396d(d) of this title, every year” in parenthetical text.

Subsec. (i)(1). Pub. L. 97-35, §2174(b), struck out par. (1) which provided that payments shall not be made with respect to any amount paid for items or services furnished under the plan after Dec. 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under fourth and fifth sentences of section 1395u(b)(3) of this title.

Subsec. (i)(5). Pub. L. 97-35, §2103(b)(1), added par. (5). Subsec. (i)(6). Pub. L. 97-35, §2164(a), added par. (6).

Subsec. (m)(1)(A). Pub. L. 97-35, §2178(a)(1), redefined “Health Maintenance Organization” substantially, and substituted reference to public and private organizations making services to individuals eligible for benefits under this subchapter and which makes adequate provision against the risk of insolvency for reference to a legal entity which provides health services to individuals enrolled in such organization and providing services and benefits to individuals eligible for benefits under specified provisions of this subchapter.

Subsec. (m)(2)(A). Pub. L. 97-35, §2178(a)(2), in cl. (ii), substituted “75 percent of the membership of the entity which is enrolled on a prepaid basis” for “one-half of the membership of the entity”, and added cls. (iii) to (vii).

Subsec. (m)(2)(D). Pub. L. 97-35, §2178(a)(3), added subpar. (D).

Subsec. (n). Pub. L. 97-35, §2106(b)(3), struck out “of this section” after “section 1395cc of this title” thereby perfecting the amendment made by Pub. L. 96-499, §905(c)(2).

Subsec. (s). Pub. L. 97-35, §2161(c)(1), as amended by Pub. L. 97-248, §137(a)(2), repealed subsec. (s) which provided for reduction in medicaid payments to States, limitations on reductions, States included, and percentage reductions reduced under certain circumstances. See Effective Date of 1981 Amendment note below.

Pub. L. 97-35, §2161(a), added subsec. (s).

Subsec. (t). Pub. L. 97-35, §2161(c)(2), as amended by Pub. L. 97-248, §137(a)(2), repealed subsec. (t) which provided for offset for meeting Federal medicaid expenditure targets, and computation for meeting expenditure targets. See Effective Date of 1981 Amendment note below.

Pub. L. 97-35, §2161(b), as amended by Pub. L. 97-248, §137(a)(1), added subsec. (t).

1980—Subsec. (a)(1). Pub. L. 96-499, §905(b), inserted reference to subsection (j) of this section.

Subsec. (a)(6). Pub. L. 96-499, §963, substituted “such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and (B) 75 percent of the sums expended during each succeeding calendar quarter” for “each quarter beginning on or after October 1, 1977, and ending before October 1, 1980”.

Subsec. (d)(5). Pub. L. 96-499, §961(a), added par. (5).

Subsec. (g)(3)(B). Pub. L. 96-499, §964, substituted “January 1, 1978” for “October 1, 1977” and “any calendar quarter ending on or before December 31, 1978” for “the calendar quarter ending on December 31, 1977”.

Subsec. (j). Pub. L. 96-499, §905(c)(1), substituted provisions relating to the adjustment of amounts deter-

mined under subsec. (a)(1) of this section in accordance with section 1396m of this title for provisions relating to orders for suspension of payment.

Subsec. (n). Pub. L. 96-499, §905(c)(2), struck out “or is subject to a suspension of payment order issued under subsection (j)” after “section 1395cc of this title”.

Subsec. (r). Pub. L. 96-398 added subsec. (r).

1979—Subsec. (m)(2)(C). Pub. L. 96-79 substituted “the date the entity qualifies as a health maintenance organization (as determined by the Secretary)” for “the date the entity enters into a contract with the State under this subchapter for the provision of health services on a prepaid risk basis”.

1978—Subsec. (m)(1)(B). Pub. L. 95-559 struck out “shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions” after “subparagraph (A)”.

Subsec. (m)(2)(B)(i)(I). Pub. L. 95-626 substituted “section 254b(d)(1)(A)” for “section 247d(d)(1)(A)”.

1977—Subsec. (a)(3)(B). Pub. L. 95-142, §10(a), inserted provisions relating to notice to individuals in a sample group and provisions exempting notice respecting confidential services from notice requirements.

Subsec. (a)(6), (7). Pub. L. 95-142, §17(a), added par. (6) and redesignated former par. (6) as (7).

Subsec. (b)(3). Pub. L. 95-142, §17(b), added par. (3).

Subsec. (g). Pub. L. 95-142, §20(a), in par. (1) substituted “Subject to paragraph (3), with respect to” for “With respect to” and “by a per centum thereof (determined under paragraph (5))” for “by 33½ per centum thereof”, in par. (2) inserted “timely” before “sample onsite surveys”, and added pars. (3) to (6).

Subsec. (i)(2). Pub. L. 95-142, §3(c)(2), inserted provisions relating to noncompliance under sections 1395cc(b)(2) and 1396a(a)(38) of this title.

Subsec. (m)(2)(A). Pub. L. 95-83, §105(a)(1), in revising text, incorporated former cl. (i) (I) and (II) provisions in introductory text relating to responsibility for providing inpatient hospital services and other described services, substituting “capitation basis” for “capitation risk basis” and inserting “unless”; redesignated as cl. (i) former cl. (ii), substituting “has determined that the entity is a health maintenance organization” for “has not determined to be a health maintenance organization”; and redesignated as cl. (ii) former cl. (iii), substituting “less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter” for “more than one-half of the membership of which consists of individuals who are insured under parts A and B of subchapter XVIII of this chapter or recipients of benefits under this subchapter.”

Subsec. (m)(2)(C). Pub. L. 95-83, §105(a)(2), substituted reference to subpar. “(A)(ii)” for “(A)(iii)” wherever appearing.

Subsec. (n). Pub. L. 95-142, §8(c), added subsec. (n).

Subsecs. (o), (p). Pub. L. 95-142, §11(a), added subsecs. (o) and (p).

Subsec. (q). Pub. L. 95-142, §17(c), added subsec. (q).

1976—Subsec. (l). Pub. L. 94-552 repealed subsec. (l) which provided for reduction of amount of payments to States found not to be in compliance with section 1396a(g) of this title.

Subsec. (m). Pub. L. 94-460 added subsec. (m).

1975—Subsec. (g)(1)(C). Pub. L. 94-182, §110(a), inserted provisions specifying the method by which the size and composition of the sample of admissions subject to review is to be established.

Subsec. (l). Pub. L. 94-182, §111(b), added subsec. (l).

1973—Subsec. (a). Pub. L. 93-233, §18(x)(5), struck out reference to section 1317 of this title in introductory parenthetical phrase.

Subsec. (a)(1). Pub. L. 93-233, §§13(a)(11), 18(r)(1), substituted “individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under

subchapter I, X, XIV, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title” for “individuals who are recipients of money payments under a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter” and inserted “and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter,” after “individuals sixty-five years of age or older”.

Subsec. (a)(4). Pub. L. 93-233, §18(s), substituted “sums expended with respect to costs incurred” for “sums expended”.

Subsec. (a)(5). Pub. L. 93-233, §18(t), struck out “(as found necessary by the Secretary for the proper and efficient administration of the plan)” after “such quarter”.

Subsec. (b). Pub. L. 93-233, §§18(r)(2), (u), (x)(6), inserted in par. (2) after “individuals sixty-five years of age or older” text reading “and disabled individuals entitled to hospital insurance benefits under subchapter XVIII” and end text reading “, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title,” and redesignated pars. (2) and (3) as (1) and (2), respectively.

Subsec. (c). Pub. L. 93-233, §18(y)(1)(A), struck out subsec. (c) which provided for Federal medical assistance percentage and Federal share of State medical expenses during fiscal year ending June 30, 1965.

Subsec. (d)(1). Pub. L. 93-233, §18(y)(1)(B), struck out reference to subsec. (c) of this section.

Subsec. (f)(4). Pub. L. 93-233, §13(a)(12), in subpar. (A), made payment limitations inapplicable to individual with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; in subpar. (B), made payment limitations inapplicable to individual with respect to whom such benefits are not being paid, and in cls. (i) and (ii) inserted “to have such benefits paid with respect to him”, and added subpar. (C).

Subsec. (g)(1)(C). Pub. L. 93-233, §18(v), substituted “directly responsible for the care of the patient or financially interested in any such institution or, except in the case of hospitals, employed by the institution” for “directly responsible for the care of the patient and who are not employed by or financially interested in any such institution”.

Subsec. (j). Pub. L. 93-66 struck out provisions respecting skilled nursing facility services and intermediate care facility services.

1972—Subsec. (a)(1). Pub. L. 92-603, §207(a)(2), inserted reference to subssecs. (g) and (h) and of this section.

Subsec. (a)(3). Pub. L. 92-603, §235(a), added par. (3). Former par. (3) redesignated (4).

Subsec. (a)(4). Pub. L. 92-603, §249B, temporarily added par. (4) which provided for payments to States of 100 per centum of sums expended for costs incurred during a quarter attributable to compensation or training of personnel responsible for inspecting public or private institutions providing long-term care to recipients of medical assistance to determine compliance with health or safety standards. Former par. 4 redesignated (5). See Effective Date of 1972 Amendment note below.

Pub. L. 92-603, §235(a), redesignated former par. (3) as (4).

Subsec. (a)(5). Pub. L. 92-603, §299E(a), added par. (5). Former par. (5) redesignated (6).

Pub. L. 92-603, §249B, redesignated former par. (4) as (5).

Subsec. (a)(6). Pub. L. 92-603, §299E, redesignated former par. (5) as (6).

Subsec. (b)(1). Pub. L. 92-603, §295, struck out par. (1) which related to amount of quarterly expenditures exceeding average of total expenditures for each quarter of fiscal year ending June 30, 1965.

Subsec. (b)(3). Pub. L. 92-603, §221(c)(6), added par. (3).
Subsec. (e). Pub. L. 92-603, §230, repealed subsec. (e) which related to furnishing for comprehensive care and services by July 1, 1977.

Subsec. (g). Pub. L. 92-603, §§207(a)(1), 278(b)(1), added subsec. (g) and substituted “skilled nursing facility” for “skilled nursing home” and “skilled nursing facilities” for “skilled nursing homes” wherever appearing.

Subsec. (h). Pub. L. 92-603, §§207(a)(1), 278(b)(1)(5), added subsec. (h) and substituted “skilled nursing facility” for “skilled nursing home” wherever appearing.

Subsec. (i). Pub. L. 92-603, §§224(c), 229(c), 233(c), 237(a)(1), 278(b)(7), added subsec. (i) and substituted “skilled nursing facility” for “skilled nursing home” wherever appearing.

Subsec. (j). Pub. L. 92-603, §290, added subsec. (j) relating to orders for suspension of payment.

Pub. L. 92-603, §§225, 278(b)(16), added subsec. (j) relating to skilled nursing facilities services, and substituted “skilled nursing facility” for “skilled nursing home” wherever appearing.

Subsec. (k). Pub. L. 92-603, §226(e), added subsec. (k).
1969—Subsec. (e). Pub. L. 91-56 extended from July 1, 1975, to July 1, 1977, the date by which comprehensive care and services for eligible individuals must be made available for a State to be eligible for payments.

1968—Subsec. (a)(1). Pub. L. 90-248, §222(d), substituted “and, except in the case of individuals sixty-five years of age or older who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums” for “and other insurance premiums”.

Pub. L. 90-248, §241(f)(5), struck out “IV,” after “I,” and inserted “or part A of subchapter IV of this chapter,” after “XVI of this chapter,”.

Subsec. (a)(2). Pub. L. 90-248, §225(a), substituted “of the State agency or any other public agency” for “of the State agency (or of the local agency administering the State plan in the political subdivision)”.

Subsec. (b). Pub. L. 90-248, §222(c), designated existing provisions as par. (1) and added par. (2).

Subsec. (b)(2). Pub. L. 90-364 substituted “1969” for “1967”.

Subsec. (d)(2). Pub. L. 90-248, §229(c), provided for treatment of expenditures for which payments were made to the State under subsec. (a) as an overpayment to the extent that the State or local agency administering the plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

Subsec. (f). Pub. L. 90-248, §220(a), added subsec. (f).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 209(a)(3) of Pub. L. 116-260 effective Dec. 27, 2020, and applicable to transportation furnished on or after such date, see section 209(a)(4) of Pub. L. 116-260, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Amendment by section 6(a)(2)(A) of Pub. L. 116-16 effective on Apr. 18, 2019, and applicable to covered outpatient drugs supplied by manufacturers under agreements under section 1396r-8 of this title on or after that date, see section 6(e) of Pub. L. 116-16, set out as a note under section 1320a-7 of this title.

Pub. L. 116-16, §8(b), Apr. 18, 2019, 133 Stat. 864, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to

items and services furnished on or after January 1, 2020.”

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115-271, title I, §1016(c), Oct. 24, 2018, 132 Stat. 3923, provided that: “The amendment made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Oct. 24, 2018].”

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114-255, div. A, title V, §5008(b), Dec. 13, 2016, 130 Stat. 1197, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning on or after the date of the enactment of this Act [Dec. 13, 2016].”

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-309, title II, §205(e), Dec. 15, 2010, 124 Stat. 3290, provided that the amendment made by section 205(e) is effective as if included in the enactment of section 4201(a)(2) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5).

Amendment by Pub. L. 111-157 effective as if included in the enactment of the HITECH Act (Pub. L. 111-5, div. A, title XIII, div. B, title IV), see section 5(b) of Pub. L. 111-157, set out as a note under section 1395w-4 of this title.

Amendment by section 2004(c)(1) of Pub. L. 111-148 effective Jan. 1, 2014, see section 2004(d) of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Pub. L. 111-148, title II, §2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by section 2102(a)(8) of Pub. L. 111-148 is effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3).

Amendment by section 2202(b) of Pub. L. 111-148 effective Jan. 1, 2014, and applicable to services furnished on or after that date, see section 2202(c) of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(a)(4)(B), (b)(2)(B) of Pub. L. 111-148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

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

Pub. L. 111-148, title VI, §6504(b)(2), Mar. 23, 2010, 124 Stat. 777, provided that: “The amendment made by paragraph (1) [amending this section] shall apply with respect to contract years beginning on or after January 1, 2010.”

Pub. L. 111-148, title VI, §6506(a)(2), Mar. 23, 2010, 124 Stat. 777, provided that: “The amendments made by this subsection [amending this section] take effect on the date of enactment of this Act [Mar. 23, 2010] and apply to overpayments discovered on or after that date.”

Amendment by sections 6504(a) and 6507 of Pub. L. 111-148 effective Jan. 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle F (§§6501-6508) of title VI of Pub. L. 111-148 have been promulgated by that date, see section 6508 of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 201(b)(2)(A), 214(a), and 401(b) of Pub. L. 111-3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see sec-

tion 3 of Pub. L. 111-3, set out as an Effective Date note under section 1396 of this title.

Amendment by section 211 of Pub. L. 111-3 effective Jan. 1, 2010, except that amendment by section 211(b)(1)-(3)(A) of Pub. L. 111-3 effective as if included in the enactment of section 6036 of Pub. L. 109-171 and amendment by section 211(b)(4) of Pub. L. 111-3 effective as if included in the enactment of section 405 of Pub. L. 109-432, with restoration of eligibility and special transition rule for Indians, see section 211(d) of Pub. L. 111-3, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-379, §3(b), Oct. 8, 2008, 122 Stat. 4075, provided that:

“(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) [amending this section] take effect on October 1, 2009.

“(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Oct. 8, 2008]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.”

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110-28, title VII, §7002(b)(2), May 25, 2007, 121 Stat. 188, as amended by Pub. L. 110-90, §5, Sept. 29, 2007, 121 Stat. 985, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to prescriptions executed after March 31, 2008.”

[Pub. L. 110-90, §5, Sept. 29, 2007, 121 Stat. 985, provided in part that the amendment by section 5 of Pub. L. 110-90 to section 7002(b)(2) of Pub. L. 110-28, set out above, is effective as if included in the enactment of section 7002(b) of Pub. L. 110-28.]

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109-432, div. B, title IV, §405(c)(1)(A), Dec. 20, 2006, 120 Stat. 2998, provided that the amendment made by section 405(c)(1)(A) is effective as if included in the amendment made by section 6036(a)(2) of the Deficit Reduction Act of 2005 [Pub. L. 109-171].

Pub. L. 109-171, title VI, §6033(b), Feb. 8, 2006, 120 Stat. 74, provided that: “The amendments made by subsection (a) [amending this section] take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act [Feb. 8, 2006].”

Pub. L. 109-171, title VI, §6036(b), Feb. 8, 2006, 120 Stat. 81, as amended by Pub. L. 109-432, div. B, title IV, §405(c)(2)(A)(v)(I), Dec. 20, 2006, 120 Stat. 3000, provided that: “The amendments made by subsection (a) [amending this section] shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(x) of the Social Security Act [42 U.S.C. 1396b(x)], as added by such amendments, was not previously met.”

Pub. L. 109-171, title VI, §6043(c), Feb. 8, 2006, 120 Stat. 88, provided that: “The amendments made by this section [amending this section and section 1396o-1 of this title] shall apply to non-emergency services furnished on or after January 1, 2007.”

Pub. L. 109-171, title VI, §6051(b), Feb. 8, 2006, 120 Stat. 92, provided that:

“(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) [amending this sec-

tion] shall be effective as of the date of the enactment of this Act [Feb. 8, 2006].

“(2) DELAY IN EFFECTIVE DATE.—

“(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

“(B) SPECIFIED STATES.—For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a Medicaid managed care organization with a contract under section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)] as of December 8, 2005.”

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

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109-91, title I, §104(d), Oct. 20, 2005, 119 Stat. 2093, provided that: “The amendments made by this section [amending this section and sections 1396r-8 and 1396u-5 of this title] shall apply to drugs dispensed on or after January 1, 2006.”

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108-357, title VII, §712(d), Oct. 22, 2004, 118 Stat. 1561, provided that: “The amendments made by subsections (a) and (b) [amending this section and section 1396d of this title] take effect on the date of enactment of this Act [Oct. 22, 2004] and apply to medical assistance and services provided under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after that date.”

EFFECTIVE DATE OF 2000 AMENDMENTS

Amendment by section 702(c)(1) of Pub. L. 106-554 effective Jan. 1, 2001, and applicable to services furnished on or after such date, see section 1(a)(6) [title VII, §702(e)] of Pub. L. 106-554, set out as a note under section 1396a of this title.

Pub. L. 106-554, §1(a)(6) [title VII, §710(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-578, provided that:

“(1) The amendment made by subsection (a)(1) [amending this section] shall be effective as if included in the enactment of section 121 of the Foster Care Independence Act of 1999 (Public Law 106-169 [amending sections 1396a and 1396d of this title and enacting provisions set out as notes under section 1396a of this title]).

“(2) The amendment made by subsection (a)(2) [amending this section] shall be effective as if included in the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354).”

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

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 201(a)(4), (b) of Pub. L. 106-170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106-170, set out as a note under section 1396a of this title.

Pub. L. 106-170, title IV, §407(d), Dec. 17, 1999, 113 Stat. 1914, provided that: “The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Dec. 17, 1999].”

Amendment by section 1000(a)(6) [title VI, §604(a)(2)(B), (b)(2)] of Pub. L. 106-113 applicable as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1396u-2(c)(2) of this title, see section 1000(a)(6) [title VI, §604(c)(2)] of Pub. L. 106-113, set out as a note under section 1396a of this title.

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §608(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A-398, provided that the amendment made by section 1000(a)(6) [title VI, §608(aa)(2)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105-33].

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

Pub. L. 106-31, title III, §3031(c), May 21, 1999, 113 Stat. 104, provided that: “This section [amending this section] and the amendments made by this section shall apply to amounts paid to a State prior to, on, or after the date of the enactment of this Act [May 21, 1999].”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, provided that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901-4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105-33.

Pub. L. 105-33, title IV, §4710, Aug. 5, 1997, 111 Stat. 506, provided that:

“(a) GENERAL EFFECTIVE DATE.—Except as otherwise provided in this chapter [chapter 1 (§§4701-4710) of subtitle H of title IV of Pub. L. 105-33, enacting section 1396u-2 of this title, amending this section and sections 1320a-3, 1320a-7b, 1396a, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-2, and 1396v of this title, and enacting provisions set out as a note under section 1396u-2 of this title] and section 4759 [enacting provisions set out as a note under section 1396a of this title], the amendments made by this chapter shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to contracts entered into or renewed on or after October 1, 1997.

“(b) SPECIFIC EFFECTIVE DATES.—Subject to subsection (c) and section 4759—

“(1) PCCM OPTION.—The amendments made by section 4702 [amending this section and sections 1396a and 1396d of this title] shall apply to primary care case management services furnished on or after October 1, 1997.

“(2) 75:25 RULE.—The amendments made by section 4703 [amending this section and section 1396r-6 of this title] apply to contracts under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) on and after June 20, 1997.

“(3) QUALITY STANDARDS.—Section 1932(c)(1) of the Social Security Act [42 U.S.C. 1396u-2(c)(1)], as added by section 4705(a), shall take effect on January 1, 1999.

“(4) SOLVENCY STANDARDS.—

“(A) IN GENERAL.—The amendments made by section 4706 [amending this section] shall apply to contracts entered into or renewed on or after October 1, 1998.

“(B) TRANSITION RULE.—In the case of an organization that as of the date of the enactment of this Act [Aug. 5, 1997] has entered into a contract under section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)] with a State for the provision of medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.] under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by section 4706 shall not apply to such organization until 3 years after the date of the enactment of this Act.

“(5) SANCTIONS FOR NONCOMPLIANCE.—Section 1932(e) of the Social Security Act [42 U.S.C. 1396u-2(e)], as added by section 4707(a), shall apply to contracts entered into or renewed on or after April 1, 1998.

“(6) LIMITATION ON FFP FOR ENROLLMENT BROKERS.—The amendment made by section 4707(b) [amending this section] shall apply to amounts expended on or after October 1, 1997.

“(7) 6-MONTH GUARANTEED ELIGIBILITY.—The amendments made by section 4709 [amending section 1396a of this title] shall take effect on October 1, 1997.

“(c) NONAPPLICATION TO WAIVERS.—Nothing in this chapter (or the amendments made by this chapter) shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n).”

Amendment by section 4712(b)(2) of Pub. L. 105-33 applicable to services furnished on or after Oct. 1, 1997, see section 4712(b)(3) of Pub. L. 105-33, set out as a note under section 1396a of this title.

Pub. L. 105-33, title IV, §4712(c), Aug. 5, 1997, 111 Stat. 509, as amended by Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §603(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-394, which provided that the amendment made by section 4712(c) was effective for services furnished on or after Oct. 1, 2004, was repealed by Pub. L. 106-554, §1(a)(6) [title VII, §702(c)(1), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A-574, effective Jan. 1, 2001, and applicable to services furnished on or after such date.

Pub. L. 105-33, title IV, §4722(d), Aug. 5, 1997, 111 Stat. 515, provided that: “The amendments made by subsection (a) [amending this section] shall apply to taxes imposed before, on, or after the date of the enactment of this Act [Aug. 5, 1997] and the amendment made by subsection (b) [amending this section] shall apply to taxes imposed on or after such date.”

Pub. L. 105-33, title IV, §4724(b)(2), Aug. 5, 1997, 111 Stat. 516, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to home health care services furnished on or after January 1, 1998.”

Pub. L. 105-33, title IV, §4742(b), Aug. 5, 1997, 111 Stat. 523, provided that: “The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Aug. 5, 1997].”

Amendment by section 4753(a) of Pub. L. 105-33 effective Jan. 1, 1998, except as otherwise specifically provided, see section 4753(c) of Pub. L. 105-33, set out as a note under section 1396a of this title.

Amendment by section 4912(b)(2) of Pub. L. 105-33 effective Aug. 5, 1997, see section 4912(c) of Pub. L. 105-33, set out as a note under section 1396a of this title.

Amendment by Pub. L. 105-12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105-12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104-248, §1(b)(2), Oct. 9, 1996, 110 Stat. 3149, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to physicians’ services furnished on or after January 1, 1992.”

Amendment by Pub. L. 104-193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104-193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13602(b) of Pub. L. 103-66 effective as if included in enactment of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, see section 13602(d)(1) of Pub. L. 103-66, set out as a note under section 1396r-8 of this title.

Pub. L. 103-66, title XIII, §13604(b), Aug. 10, 1993, 107 Stat. 621, provided that:

“(1) Subject to paragraph (2), the amendments made by subsection (a) [amending this section] shall apply as if included in the enactment of OBRA-1986 [Pub. L. 99-509].

“(2) The Secretary of Health and Human Services shall not disallow expenditures made for the care and services described in section 1903(v)(2)(C) of the Social Security Act [42 U.S.C. 1396b(v)(2)(C)], as added by subsection (a), furnished before the date of the enactment of this Act [Aug. 10, 1993].”

Amendment by section 13622(a)(2) of Pub. L. 103-66 applicable to items and services furnished on or after Oct. 1, 1993, see section 13622(d)(3) of Pub. L. 103-66, set out as a note under section 1396a of this title.

Pub. L. 103-66, title XIII, §13624(b), Aug. 10, 1993, 107 Stat. 636, provided that: “The amendment made by subsection (a) [amending this section] shall apply to referrals made on or after December 31, 1994.”

Pub. L. 103-66, title XIII, §13631(h)(2), Aug. 10, 1993, 107 Stat. 645, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to amounts expended for vaccines administered on or after October 1, 1993.”

Amendment by section 13631(c) of Pub. L. 103-66 applicable to payments under State plans approved under this subchapter for calendar quarters beginning on or after Oct. 1, 1994, see section 13631(i) of Pub. L. 103-66, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1991 AMENDMENT

Amendments by section 2(a), (b)(2) of Pub. L. 102-234 effective Jan. 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date, see section 2(c)(1) of Pub. L. 102-234, set out as a note under section 1396a of this title.

Amendment by section 3(b)(2)(B) of Pub. L. 102-234 effective Jan. 1, 1992, see section 3(e)(1) of Pub. L. 102-234, set out as a note under section 1396a of this title.

Pub. L. 102-234, §4(b), Dec. 12, 1991, 105 Stat. 1804, provided that: “The amendment made by subsection (a) [amending this section] shall apply to fiscal years ending after the date of the enactment of this Act [Dec. 12, 1991].”

EFFECTIVE DATE OF 1990 AMENDMENTS

Amendment by section 4402(b), (d)(3) of Pub. L. 101-508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101-508 have been promulgated by such date, see section 4402(e) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Amendment by section 4601(a)(3)(A) of Pub. L. 101-508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4601 of Pub. L. 101-508 have been promulgated by such date, see section 4601(b) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Pub. L. 101-508, title IV, §4701(c), Nov. 5, 1990, 104 Stat. 1388-171, provided that: “The amendment made by subsection (b) [amending this section and section 1396a of this title] shall take effect on January 1, 1991.”

Amendment by section 4704(b)(1), (2) of Pub. L. 101-508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, see section 4704(f) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Amendment by section 4711(c)(2) of Pub. L. 101-508 applicable to civil money penalties imposed after Nov. 5, 1990, see section 4711(e)(2)(B) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Pub. L. 101-508, title IV, §4731(c), Nov. 5, 1990, 104 Stat. 1388-195, provided that: “The amendments made by subsections (a) and (b)(2) [amending this section]

shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by subsection (b)(1) [amending section 1320a-7a of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].”

Amendment by section 4751(b)(1) of Pub. L. 101-508 applicable with respect to services furnished on or after first day of first month beginning more than 1 year after Nov. 5, 1990, see section 4751(c) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Pub. L. 101-508, title IV, § 4752(b)(2), Nov. 5, 1990, 104 Stat. 1388-206, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning after the date of the establishment of the system described in section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)].”

Pub. L. 101-508, title IV, § 4801(a)(9), Nov. 5, 1990, 104 Stat. 1388-212, provided that: “Except as provided in paragraph (6), the amendments made by this subsection [amending this section and section 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203].”

Pub. L. 101-508, title IV, § 4801(e)(16)(B), Nov. 5, 1990, 104 Stat. 1388-218, provided that: “The amendments made by subparagraph (A) [amending this section] shall apply with respect to actions initiated on or after the date of the enactment of this Act [Nov. 5, 1990].”

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6401(b) of Pub. L. 101-239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out the amendments by section 6401 of Pub. L. 101-239 have been promulgated by such date, see section 6401(c) of Pub. L. 101-239, set out as a note under section 1396a of this title.

Amendment by section 6901(b)(5)(A) of Pub. L. 101-239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, see section 6901(b)(6) of Pub. L. 101-239, set out as a note under section 1395i-3 of this title.

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

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 608(d)(26)(K)(ii) of Pub. L. 100-485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 608(f)(4) of Pub. L. 100-485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 202(h)(2) of Pub. L. 100-360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100-360, set out as a note under section 1395u of this title.

Pub. L. 100-360, title III, § 301(f), July 1, 1988, 102 Stat. 750, provided that the amendment made by that section is effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-509.

Amendment by section 302(c)(3) of Pub. L. 100-360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after that date, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, see section 302(f) of Pub. L. 100-360, set out as a note under section 1396a of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(a)(3)(A), (B)(iii), (k)(6)(B)(x), (7)(A), (D), (10)(D), (G)(ii) of Pub. L. 100-360,

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

Pub. L. 100-360, title IV, § 411(k)(12)(B), July 1, 1988, 102 Stat. 798, provided that: “The amendment made by subparagraph (A) [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [July 1, 1988].”

Pub. L. 100-360, title IV, § 411(k)(13)(B), July 1, 1988, 102 Stat. 798, provided that: “The amendment made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988].”

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100-203, title IV, § 4118(d)(2), Dec. 22, 1987, 101 Stat. 1330-155, provided that: “The amendments made by paragraph (1) [amending this section] shall be effective as if included in the enactment of section 9507 of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272].”

Amendment by section 4118(h)(1) of Pub. L. 100-203 applicable to costs incurred after Dec. 22, 1987, see section 4118(h)(3) of Pub. L. 100-203, as amended, set out as a note under section 1396a of this title.

Amendments by sections 4211(d)(1), (g), (i), 4212(c)(1), (2), (d)(1), (e)(2) of Pub. L. 100-203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100-203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by section 4212(d)(1) of Pub. L. 100-203 not applicable until such date as of which the State has specified the resident assessment instrument under section 1396r(e)(5) of this title, and the State has begun conducting surveys under section 1396r(g)(2) of this title, see section 4212(d)(4) of Pub. L. 100-203, set out as a note under section 1396a of this title.

Amendment by section 4213(b)(2) of Pub. L. 100-203 applicable to payments under this subchapter for calendar quarters beginning on or after Dec. 22, 1987, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, see section 4214(b)(1) of Pub. L. 100-203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100-93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100-93, set out as a note under section 1320a-7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99-603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99-603, set out as a note under section 502 of this title.

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

Amendment by section 9401(e)(2) of Pub. L. 99-509 applicable to medical assistance furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, see section 9401(f) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Amendment by section 9403(g)(2) of Pub. L. 99-509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, with-

out regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Amendment by section 9406(a) of Pub. L. 99-509 applicable, except as otherwise provided, to medical assistance furnished to aliens on or after Jan. 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9406(c) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Amendment by section 9407(c) of Pub. L. 99-509 applicable to ambulatory prenatal care furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9407(d) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Amendment by section 9431(b)(2) of Pub. L. 99-509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9431(c) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Pub. L. 99-509, title IX, §9434(a)(3), Oct. 21, 1986, 100 Stat. 2069, provided that:

“(A) The amendments made by paragraph (1) [amending this section] shall take effect 6 months after the date of the enactment of this Act [Oct. 21, 1986].

“(B) The amendment made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act and shall apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on the date of the enactment of this Act.”

Amendment by section 9503(b), (f) of Pub. L. 99-272 applicable to calendar quarters beginning on or after Apr. 7, 1986, except as otherwise provided, see section 9503(g)(1), (2) of Pub. L. 99-272, set out as a note under section 1396a of this title.

Pub. L. 99-272, title IX, §9507(b), Apr. 7, 1986, 100 Stat. 210, provided that: “The amendments made by subsection (a) [amending this section] shall apply to medical assistance furnished on or after January 1, 1987.”

Pub. L. 99-272, title IX, §9512(b), Apr. 7, 1986, 100 Stat. 213, provided that: “The amendments made by this section [amending this section] shall apply to overpayments identified for quarters beginning on or after October 1, 1985.”

Pub. L. 99-272, title IX, §9517(c)(2), (3), Apr. 7, 1986, 100 Stat. 216, as amended by Pub. L. 99-509, title IX, §9435(e), Oct. 21, 1986, 100 Stat. 2070; Pub. L. 99-514, title XVIII, §1895(c)(4), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 101-508, title IV, §4734, Nov. 5, 1990, 104 Stat. 1388-196; Pub. L. 104-240, §1(a), Oct. 8, 1996, 110 Stat. 3140; Pub. L. 106-554, §1(a)(6) [title VII, §704(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-575; Pub. L. 110-275, title II, §205(a), July 15, 2008, 122 Stat. 2593, provided that:

“(2)(A) Except as provided in subparagraph (B) and in paragraph (3), the amendments made by paragraph (1) [amending this section] shall apply to expenditures incurred for health insuring organizations which first become operational on or after January 1, 1986. For purposes of this paragraph, a health insuring organization is not considered to be operational until the date on which it first enrolls patients.

“(B) In the case of a health insuring organization—
“(i) which first becomes operational on or after January 1, 1986, but

“(ii) for which the Secretary of Health and Human Services has waived, under section 1915(b) of the Social Security Act [42 U.S.C. 1396n(b)] and before such date, certain requirements of section 1902 of such Act [42 U.S.C. 1396a],

clauses (ii) and (vi) of section 1903(m)(2)(A) of such Act [42 U.S.C. 1396b(m)(2)(A)(ii), (vi)] shall not apply during the period for which such waiver is effective.

“(C) In the case of the Hartford Health Network, Inc., clauses (ii) and (vi) of section 1903(m)(2)(A) of the So-

cial Security Act shall not apply during the period for which a waiver by the Secretary of Health and Human Services, under section 1915(b) of such Act, of certain requirements of section 1902 of such Act is in effect pursuant to a request for a waiver under section 1915(b) of such Act submitted before January 1, 1986).

“(D) Nothing in section 1903(m)(1)(A) of the Social Security Act shall be construed as requiring a health-insuring organization to be organized under the health maintenance organization laws of a State.

“(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County, which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

“(B) A health insuring organization described in this subparagraph is one that—

“(i) is operated directly by a public entity established by a county government in the State of California under a State enabling statute;

“(ii) enrolls all medicaid beneficiaries residing in the county or counties in which it operates;

“(iii) meets the requirements for health maintenance organizations under the Knox-Keene Act (Cal. Health and Safety Code, section 1340 et seq.) and the Waxman-Duffy Act (Cal. Welfare and Institutions Code, section 14450 et seq.);

“(iv) assures a reasonable choice of providers, which includes providers that have historically served medicaid beneficiaries and which does not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary;

“(v) provides for a payment adjustment for a disproportionate share hospital (as defined under State law consistent with section 1923 of the Social Security Act [42 U.S.C. 1396r-4]) in a manner consistent with the requirements of such section; and

“(vi) provides for payment, in the case of children's hospital services provided to medicaid beneficiaries who are under 21 years of age, who are children with special health care needs under title V of the Social Security Act [42 U.S.C. 701 et seq.], and who are receiving care coordination services under such title, at rates determined by the California Medical Assistance Commission.

“(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds 16 percent of the number of such beneficiaries in the State of California.

“(D) In this paragraph, the term ‘medicaid beneficiary’ means an individual who is entitled to medical assistance under the State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than a qualified medicare beneficiary who is only entitled to such assistance because of section 1902(a)(10)(E) of such title [42 U.S.C. 1396a(a)(10)(E)].”

[Pub. L. 110-275, title II, §205(b), July 15, 2008, 122 Stat. 2594, provided that: “The amendments made by subsection (a) [amending section 9517(c)(3)(A), (C) of Pub. L. 99-272, set out above] shall take effect on the date of the enactment of this Act [July 15, 2008].”]

[Pub. L. 106-554, §1(a)(6) [title VII, §704(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-575, provided that: “The amendment made by subsection (a) [amending section 9517(c)(3)(C) of Pub. L. 99-272, set out above] takes effect on the date of the enactment of this Act [Dec. 21, 2000].”]

[Pub. L. 104-240, §1(b), Oct. 8, 1996, 110 Stat. 3140, provided that: “The amendment made by subsection (a)

[amending section 9517(c)(3)(B)(ii) of Pub. L. 99-272, set out above] shall apply to quarters beginning on or after October 1, 1996.”]

Pub. L. 99-272, title IX, §9518(b), Apr. 7, 1986, 100 Stat. 216, provided that: “The amendment made by subsection (a) [amending this section] shall apply to payment under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for calendar quarters beginning on or after October 1, 1982.”

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98-369, see section 3(c) of Pub. L. 98-617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(2) of Pub. L. 98-369 applicable to payments for calendar quarters beginning on or after Oct. 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98-21, set out as a note under section 1395j of this title, see section 2303(j)(2) 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, §2363(c), July 18, 1984, 98 Stat. 1107, provided that: “The amendments made by subsection (a) [amending this section and section 1396a of this title] apply to calendar quarters beginning on or after the date of the enactment of this Act [July 18, 1984], except that, in the case of individuals admitted to skilled nursing facilities before such date, the amendments made by such subsection shall not require recertifications sooner or more frequently than were required under the law in effect before such date.”

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97-448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, see section 309(c)(2) of Pub. L. 97-448, set out as a note under section 426-1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97-248, title I, §133(b), Sept. 3, 1982, 96 Stat. 374, provided that: “The amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Sept. 3, 1982].”

Amendment by section 137(a)(1), (2) of Pub. L. 97-248 effective as if originally included in the provision of the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, to which such amendment relates, see section 137(d)(1) of Pub. L. 97-248, set out as a note under section 1396a of this title.

Amendment by section 137(b)(11)-(16), (27) of Pub. L. 97-248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, see section 137(d)(2) of Pub. L. 97-248, set out as a note under section 1396a of this title.

Pub. L. 97-248, title I, §137(g), Sept. 3, 1982, 96 Stat. 381, provided that the amendment made by that section is effective Oct. 1, 1982.

Amendment by section 146(b) of Pub. L. 97-248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97-248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2101(a)(2) of Pub. L. 97-35 applicable only to services furnished by a hospital during any accounting year beginning on or after Oct. 1, 1981, see section 2101(c) of Pub. L. 97-35, set out as an Effective Date note under section 1395uu of this title.

Pub. L. 97-35, title XXI, §2103(b)(2), Aug. 13, 1981, 95 Stat. 788, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to amounts expended on or after October 1, 1981.”

Amendment by section 2113(n) of Pub. L. 97-35 applicable to agreements with Professional Standards Review Organizations entered into on or after Oct. 1, 1981, see section 2113(o) of Pub. L. 97-35, set out as a note under section 1396a of this title.

Pub. L. 97-35, title XXI, §2161(c)(1), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97-248, title I, §137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided that the amendment made by such section 2161(c)(1) is effective for calendar quarters beginning on or after Oct. 1, 1984.

Pub. L. 97-35, title XXI, §2161(c)(2), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97-248, title I, §137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided that the amendment made by such section 2161(c)(2) is effective after payments for the first quarter of fiscal year 1985.

Pub. L. 97-35, title XXI, §2164(b), Aug. 13, 1981, 95 Stat. 806, provided that: “The amendments made by subsection (a) [amending this section] shall apply to tests occurring on or after October 1, 1981.”

Amendment by section 2174(b) of Pub. L. 97-35 applicable to services furnished on or after Oct. 1, 1981, see section 2174(c) of Pub. L. 97-35, set out as a note under section 1396a of this title.

Amendment by section 2178(a) of Pub. L. 97-35 applicable with respect to services furnished, under a State plan approved under this subchapter, on or before Oct. 1, 1981, except that such amendments not applicable with respect to services furnished by a health maintenance organization under a contract with a State entered into under this subchapter before Oct. 1, 1981, unless the organization requests that such amendments apply and the Secretary and the State agency agree to such request, see section 2178(c) of Pub. L. 97-35, set out as a note under section 1396a of this title.

Pub. L. 97-35, title XXI, §2183(b), Aug. 13, 1981, 95 Stat. 816, provided that: “The amendments made by subsection (a) [amending this section] shall apply to payments made to States for calendar quarters beginning on or after October 1, 1981.”

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96-499, title IX, §961(b), Dec. 5, 1980, 94 Stat. 2650, provided that: “The amendment made by subsection (a) [amending this section] shall be effective with respect to expenditures for services furnished on or after October 1, 1980.”

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 3(c)(2) of Pub. L. 95-142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95-142, set out as an Effective Date note under section 1320a-3 of this title.

Amendment by section 8(c) of Pub. L. 95-142 effective with respect to contracts, agreements, etc., made on and after the first day of the fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95-142, set out as an Effective Date note under section 1320a-5 of this title.

Pub. L. 95-142, §10(b), Oct. 25, 1977, 91 Stat. 1196, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after the date of the enactment of this Act [Oct. 25, 1977].”

Pub. L. 95-142, §11(c), Oct. 25, 1977, 91 Stat. 1197, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after January 1, 1978.”

Pub. L. 95-142, §17(e)(1), Oct. 25, 1977, 91 Stat. 1202, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after September 30, 1977.”

Pub. L. 95-142, §20(c), Oct. 25, 1977, 91 Stat. 1207, as amended by Pub. L. 95-292, §8(e), June 13, 1978, 92 Stat. 316, provided that:

“(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396a of this title] shall be effective on October

1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act [42 U.S.C. 1396b] to reflect the changes made by such amendments.

“(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act [42 U.S.C. 1396b(g)(1)] because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section 1903(g) of such Act [42 U.S.C. 1396b(g)(4)(B)], as added by this section, shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1, 1977.”

Pub. L. 95-83, title I, §105(a)(3), Aug. 1, 1977, 91 Stat. 384, provided that: “The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to States for services provided—

“(A) after October 8, 1976, under contracts under such title [42 U.S.C. 1396 et seq.] entered into or renegotiated after such date, or

“(B) after the expiration of the one-year period beginning on such date, whichever occurs first.”

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94-552 effective Jan. 1, 1976, see section 2 of Pub. L. 94-552, set out as a note under section 1396a of this title.

Pub. L. 94-460, title II, §202(b), Oct. 8, 1976, 90 Stat. 1959, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to States for services provided—

“(1) after the date of enactment of subsection (a) [Oct. 8, 1976] under contracts under such title entered into or renegotiated after such date, or

“(2) after the expiration of the 1-year period beginning on such date of enactment, whichever occurs first.”

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94-182, title I, §110(b), Dec. 31, 1975, 89 Stat. 1054, provided that: “The amendment made by subsection (a) [amending this section] shall take effect on the first day of the first calendar month which begins not less than 90 days after the date of enactment of this Act [Dec. 31, 1975].”

Amendment by section 111(b) of Pub. L. 94-182 effective January 1, 1976, except as otherwise provided therein, see section 111(c) of Pub. L. 94-182, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(11), (12) of Pub. L. 93-233 effective with respect to payments under this section for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93-233, set out as a note under section 1396a of this title.

Amendment by section 18(u) of Pub. L. 93-233 effective July 1, 1973, see section 18(z-3)(4) of Pub. L. 93-233, set out as a note under section 1396a of this title.

Pub. L. 93-66, title II, §234(b), July 9, 1973, 87 Stat. 160, provided that: “The amendment made by subsection (a) [amending this section] shall be applicable in the case of expenditures for skilled nursing services and for intermediate care facility services furnished in calendar quarters which begin after December 31, 1972.”

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92-603, title II, §207(b), Oct. 30, 1972, 86 Stat. 1380, provided that: “The amendments made by sub-

section (a) [amending this section] shall, except as otherwise provided therein, be effective July 1, 1973.”

Amendment by section 226(e) of Pub. L. 92-603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92-603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 233(c) of Pub. L. 92-603 applicable with respect to services furnished by hospitals in accounting periods beginning after Dec. 31, 1972, see section 233(f) of Pub. L. 92-603, set out as a note under section 1395f of this title. See, also, section 16 of Pub. L. 93-233, set out as an Effective Date note under section 1395f of this title.

Pub. L. 92-603, title II, §235(b), Oct. 30, 1972, 86 Stat. 1414, provided that: “The amendments made by subsection (a) [amending this section] shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], made after June 30, 1971.”

Pub. L. 92-603, title II, §237(d)(1), Oct. 30, 1972, 86 Stat. 1416, provided that: “The amendments made by subsections (a)(1) and (b) [amending this section and section 706 of this title] shall apply with respect to services furnished in calendar quarters beginning after June 30, 1973.”

Pub. L. 92-603, title II, §249B, Oct. 30, 1972, 86 Stat. 1428, as amended by Pub. L. 93-368, §8, Aug. 7, 1974, 88 Stat. 422; Pub. L. 95-83, title III, §309(b), Aug. 1, 1977, 91 Stat. 396, provided that the amendment made by that section is effective for period beginning Oct. 1, 1972, and ending Sept. 30, 1980.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90-248, title II, §220(b), Jan. 2, 1968, 81 Stat. 899, provided that:

“(b)(1) In the case of any State whose plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] is approved by the Secretary of Health, Education, and Welfare under section 1902 [42 U.S.C. 1396a] after July 25, 1967, the amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after the date of enactment of this Act [Jan. 2, 1968].

“(2) In the case of any State whose plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] was approved by the Secretary of Health, Education, and Welfare under section 1902 of the Social Security Act [42 U.S.C. 1396a] prior to July 26, 1967, amendments made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1968, except that—

“(A) with respect to the third and fourth calendar quarters of 1968, such subsection shall be applied by substituting in subsection (f) of section 1903 of the Social Security Act [42 U.S.C. 1396b(f)] 150 percent for 133½ percent each time such latter figure appears in such subsection (f), and

“(B) with respect to all calendar quarters during 1969, such subsection shall be applied by substituting in subsection (f) of section 1903 of such Act [42 U.S.C. 1396b(f)] 140 percent for 133½ percent each time such latter figure appears in such subsection (f).”

Pub. L. 90-248, title II, §222(d), Jan. 2, 1968, 81 Stat. 901, as amended by Pub. L. 90-364, title III, §303(a)(2), June 29, 1968, 82 Stat. 274, provided that the amendment made by such section 222(d) is effective with respect to calendar quarters beginning after December 31, 1969.

Pub. L. 90-248, title II, §225(b), Jan. 2, 1968, 81 Stat. 902, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to expenditures made after December 31, 1967.”

Pub. L. 90-364, title III, §303(b), June 29, 1968, 82 Stat. 274, provided that: “The amendments made by subsection (a) [amending this section] shall be effective with respect to calendar quarters beginning after December 31, 1967.”

REGULATIONS

Pub. L. 111-148, title VI, §6506(b), Mar. 23, 2010, 124 Stat. 777, provided that: “The Secretary [of Health and

Human Services] shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.”

Pub. L. 102-234, § 5, Dec. 12, 1991, 105 Stat. 1804, provided that:

“(a) IN GENERAL.—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act [see Short Title of 1991 Amendment note set out under section 1305 of this title] and the amendments made by this Act.

“(b) REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act [42 U.S.C. 1396b(w)(6)(A)] (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

“(c) CONSULTATION WITH STATES.—The Secretary shall consult with the States before issuing any regulations under this Act.”

Secretary of Health and Human Services to promulgate final regulations necessary to carry out subsec. (r)(6)(j) of this section within 6 months after Apr. 7, 1986, see section 9503(c) of Pub. L. 99-272, set out as a note under section 1396a of this title.

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

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

IMPLEMENTATION OF SUBSECTIONS (i)(22) AND (x) REQUIREMENTS

Pub. L. 109-171, title VI, §6036(c), Feb. 8, 2006, 120 Stat. 81, as amended by Pub. L. 109-432, div. B, title IV, §405(c)(2)(A)(v)(II), Dec. 20, 2006, 120 Stat. 3000, provided that: “As soon as practicable after the date of enactment of this Act [Feb. 8, 2006], the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(22) and (x) of section 1903 of the Social Security Act [42 U.S.C. 1396b(i)(22), (x)] (as added by subsection (a)) about such requirements and how they may be satisfied.”

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by section 5005 of Pub. L. 114-255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114-255, set out as a note under section 1396a of this title.

Pub. L. 114-255, div. B, title XII, §12006(c), Dec. 13, 2016, 130 Stat. 1277, provided that:

“(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section [amending this section] may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

“(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

“(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries’ selection of a caregiver, or impede the manner in which care is delivered.

“(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.”

CONSTRUCTION OF 2015 AMENDMENT

Pub. L. 114-113, div. O, title V, §503(a)(2), Dec. 18, 2015, 129 Stat. 3021, provided that: “Nothing in the amendments made by paragraph (1) [amending this section] shall be construed to prohibit a State Medicaid program from providing medical assistance for durable medical equipment for which payment is denied or not available under the Medicare program under title XVIII of such Act [act Aug. 14, 1935, ch. 531, 42 U.S.C. 1395 et seq.]”

SECURITY AND PRIVACY

Pub. L. 115-271, title I, §1016(b), Oct. 24, 2018, 132 Stat. 3923, provided that: “All applicable State and Federal security and privacy protections and laws shall apply to any State agency, individual, or entity accessing 1 or more prescription drug monitoring program databases or obtaining information in such databases in accordance with section 1903(m)(8) of the Social Security Act [42 U.S.C. 1396b(m)(8)] (as added by subsection (a)).”

COLLECTION AND DISSEMINATION OF BEST PRACTICES

Pub. L. 114-255, div. B, title XII, §12006(b), Dec. 13, 2016, 130 Stat. 1277, provided that: “Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to—

“(1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (l)(5)); and

“(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.”

CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS

Pub. L. 111-3, title VI, §615, Feb. 4, 2009, 123 Stat. 102, provided that:

“(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State’s use of funds as the non-Federal

share of expenditures under title XIX of such Act [42 U.S.C. 1396 et seq.] where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

“(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

- “(1) provides level 1 trauma and burn care services;
- “(2) provides level 3 neonatal care services;
- “(3) is obligated to serve all patients, regardless of ability to pay;
- “(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;
- “(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and
- “(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r-4) in at least one State other than the State in which the center is located.”

Pub. L. 108-173, title X, §1001(e), Dec. 8, 2003, 117 Stat. 2431, provided that:

“(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary [of Health and Human Services] as prohibiting a State’s use of funds as the non-Federal share of expenditures under title XIX of such Act [42 U.S.C. 1396 et seq.] where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

“(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

- “(A) provides level 1 trauma and burn care services;
- “(B) provides level 3 neonatal care services;
- “(C) is obligated to serve all patients, regardless of State of origin;
- “(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);
- “(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and
- “(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act [42 U.S.C. 1396r-4] in at least one State other than the one in which the center is located.

“(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2005.”

TREATMENT OF DONATION OR TAX PROCEEDS PRIOR TO EFFECTIVE DATE OF SUBSECTION (w)

Pub. L. 102-234, §2(c)(2), Dec. 12, 1991, 105 Stat. 1799, provided that: “Except as specifically provided in section 1903(w) of the Social Security Act [42 U.S.C. 1396b(w)] and notwithstanding any other provision of such Act [42 U.S.C. 301 et seq.], the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure.”

TEMPORARY INCREASE IN FEDERAL MATCH FOR ADMINISTRATIVE COSTS

Pub. L. 101-508, title IV, §4401(b)(2), Nov. 5, 1990, 104 Stat. 1388-159, provided that: “The per centum to be ap-

plied under section 1903(a)(7) of the Social Security Act [42 U.S.C. 1396b(a)(7)] for amounts expended during calendar quarters in fiscal year 1991 which are attributable to administrative activities necessary to carry out section 1927 (other than subsection (g)) of such Act [42 U.S.C. 1396r-8] shall be 75 percent, rather than 50 percent; after fiscal year 1991, the match shall revert back to 50 percent.”

REPORT ON ERRORS IN ELIGIBILITY DETERMINATIONS; ERROR RATE TRANSITION RULES

Pub. L. 101-508, title IV, §4607, Nov. 5, 1990, 104 Stat. 1388-170, directed Secretary of Health and Human Services to report to Congress, by not later than July 1, 1991, on error rates by States in determining eligibility of individuals described in subparagraph (A) or (B) of section 1396a(l)(1) of this title for medical assistance under plans approved under this subchapter, and directed that there should not be taken into account, for purposes of subsec. (u) of this section, payments and expenditures for medical assistance attributable to medical assistance for individuals described in such subparagraph (A) or (B), and made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the Secretary’s report.

MEDICALLY NEEDED INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES

Pub. L. 101-508, title IV, §4718, Nov. 5, 1990, 104 Stat. 1388-193, provided that:

“(a) IN GENERAL.—For purposes of section 1903(f)(1)(B) [probably means section 1903(f)(1)(B) of the Social Security Act, 42 U.S.C. 1396b(f)(1)(B)], for payments made before, on, or after the date of the enactment of this Act [Nov. 5, 1990], a State described in subparagraph (B) may use, in determining the ‘highest amount which would ordinarily be paid to a family of the same size’ (under the State’s plan approved under part A of title IV of such Act [probably means 42 U.S.C. 601 et seq.]) in the case of a family consisting only of one individual and without regard to whether or not such plan provides for aid to families consisting only of one individual, an amount reasonably related to the highest money payment which would ordinarily be made under such a plan to a family of two without income or resources.

“(b) STATES COVERED.—Subsection (a) shall only apply to a State the State plan of which (under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) as of June 1, 1989, provided for the policy described in such paragraph. For purposes of the previous sentence, a State plan includes all the matter included in a State plan under section 2373(c)(5) of the Deficit Reduction Act of 1984 [Pub. L. 98-369, set out as a note under section 1396a of this title] (as amended by section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987 [Pub. L. 100-93]).”

DAY HABILITATION AND RELATED SERVICES

Pub. L. 101-239, title VI, §6411(g), Dec. 19, 1989, 103 Stat. 2272, provided that:

“(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS.—Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not—

- “(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act [42 U.S.C. 1396d(a)(9), (13)] on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or
- “(B) withdraw Federal approval of any such State plan provision.

“(2) REQUIREMENTS FOR REGULATION.—A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that—

“(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

“(B) any requirements respecting such coverage.

“(3) PROSPECTIVE APPLICATION OF REGULATION.—If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.”

NURSE AIDE TRAINING AND EVALUATION PROGRAMS;
ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990

Pub. L. 101-239, title VI, § 6901(b)(5)(B), Dec. 19, 1989, 103 Stat. 2299, provided that: “In making payments under section 1903(a)(2)(B) of the Social Security Act [42 U.S.C. 1396b(a)(2)(B)] for amounts expended for nurse aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such Act [42 U.S.C. 1396r(e)(1)], in the case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act [42 U.S.C. 1395 et seq., 1396 et seq.]”

CLARIFICATION OF FEDERAL MATCHING RATE FOR
SURVEY AND CERTIFICATION ACTIVITIES

Pub. L. 101-239, title VI, § 6901(d)(2), Dec. 19, 1989, 103 Stat. 2300, provided that: “During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for so much of the sums expended under a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent.”

QUALITY CONTROL TRANSITION PROVISIONS

Pub. L. 100-485, title VI, § 608(h), Oct. 13, 1988, 102 Stat. 2424, provided that: “There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act [42 U.S.C. 1396b(u)], payments and expenditures for medical assistance which are made on or after January 1, 1989, and before July 1, 1989, and which are attributable to medicare-cost [sic] sharing for qualified medicare beneficiaries (as defined in section 1905(p) of such Act [42 U.S.C. 1396d(p)]).”

DELAY QUALITY CONTROL SANCTIONS FOR MEDICAID

Pub. L. 100-203, title IV, § 4117, Dec. 22, 1987, 101 Stat. 1330-154, provided that: “The Secretary of Health and Human Services shall not, prior to July 1, 1988, implement any reductions in payments to States pursuant to section 1903(u) of the Social Security Act [42 U.S.C. 1396b(u)] (or any provision of law described in subsection (c) of section 133 of the Tax Equity and Fiscal Responsibility Act of 1982 [section 133(c) of Pub. L. 97-248, set out below].”

TEMPORARY TECHNICAL ERROR DEFINITION

Pub. L. 100-203, title IV, § 4118(n), Dec. 22, 1987, 101 Stat. 1330-157, provided that: “For purposes of section 1903(u)(1)(E)(ii) of the Social Security Act [42 U.S.C. 1396b(u)(1)(E)(ii)], effective for the period beginning on the date of enactment of this Act [Dec. 22, 1987] and ending December 31, 1988, a ‘technical error’ is an error in eligibility condition (such as assignment of social security numbers and assignment of rights to third-party

benefits as a condition of eligibility) that, if corrected, would not result in a difference in the amount of medical assistance paid.”

ENHANCED FUNDING FOR NURSE AIDE TRAINING

Pub. L. 100-203, title IV, § 4211(d)(2), Dec. 22, 1987, 101 Stat. 1330-204, as amended by Pub. L. 100-360, title IV, § 411(j)(3)(F), July 1, 1988, 102 Stat. 803, provided that: “For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988), with respect to payment under section 1903(a)(2)(B) of the Social Security Act [42 U.S.C. 1396b(a)(2)(B)] to a State for additional amounts expended by the State under its plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such title [42 U.S.C. 1396r(e)(1)], any reference to ‘50 percent’ is deemed a reference to the sum of the Federal medical assistance percentage (determined under section 1905(b) of such Act [42 U.S.C. 1396d(b)]) plus 25 percentage points, but not to exceed 90 percent.”

EXPENSES INCURRED FOR REVIEW OF CARE PROVIDED
TO RESIDENTS OF NURSING FACILITIES

Pub. L. 100-203, title IV, § 4212(c)(3), Dec. 22, 1987, 101 Stat. 1330-212, provided that: “For purposes of section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)], proper expenses incurred by a State for medical review by independent professionals of the care provided to residents of nursing facilities who are entitled to medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.] shall be reimbursable as expenses necessary for the proper and efficient administration of the State plan under that title.”

QUALITY CONTROL STUDIES AND PENALTY MORATORIUM

Pub. L. 99-272, title XII, § 12301, Apr. 7, 1986, 100 Stat. 291, as amended by Pub. L. 99-514, title XVII, § 1710, Oct. 22, 1986, 100 Stat. 2783; Pub. L. 100-485, title VI, § 609(b), Oct. 13, 1988, 102 Stat. 2425, provided that:

“(a) STUDIES.—(1) The Secretary of Health and Human Services (hereafter referred to in this section as the ‘Secretary’) shall conduct a study of quality control systems for the Aid to Families with Dependent Children Program under title IV-A of the Social Security Act [42 U.S.C. 601 et seq.] and for the Medicaid Program under title XIX of such Act [42 U.S.C. 1396 et seq.]. The study shall examine how best to operate such systems in order to obtain information which will allow program managers to improve the quality of administration, and provide reasonable data on the basis of which Federal funding may be withheld for States with excessive levels of erroneous payments.

“(2) The Secretary shall also contract with the National Academy of Sciences to conduct a concurrent independent study for the purpose described in paragraph (1). For purposes of such study, the Secretary shall provide to the National Academy of Sciences any relevant data available to the Secretary at the onset of the study and on an ongoing basis.

“(3) The Secretary and the National Academy of Sciences shall report the results of their respective studies to the Congress within one year after the date the Secretary and the National Academy of Sciences enter into the contract required under paragraph (2).

“(b) MORATORIUM ON PENALTIES.—(1) During the 24-month period beginning with the first calendar quarter which begins after the date of the enactment of this Act [Apr. 7, 1986] (hereafter in this section referred to as the ‘moratorium period’), the Secretary shall not impose any reductions in payments to States pursuant to section 403(i) of the Social Security Act [42 U.S.C. 603(i)] (or prior regulations), or pursuant to any comparable provision of law relating to the programs under title IV-A of such Act [42 U.S.C. 601 et seq.] in Puerto Rico, Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands.

“(2) During the moratorium period, the Secretary and the States shall continue to operate the quality control

systems in effect under title IV-A of the Social Security Act, and to calculate the error rates under the provisions referred to in paragraph (1).

“(c) RESTRUCTURED QUALITY CONTROL SYSTEMS.—(1) Not later than 6 months after the date on which the results of both studies required under subsection (a)(3) have been reported, the Secretary shall publish regulations which shall—

“(A) restructure the quality control systems under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to the extent the Secretary determines to be appropriate, taking into account the studies conducted under subsection (a); and

“(B) establish, taking into account the studies conducted under subsection (a), criteria for adjusting the reductions which shall be made for quarters prior to the implementation of the restructured quality control systems so as to eliminate reductions for those quarters which would not be required if the restructured quality control systems had been in effect during those quarters.

“(2) Beginning with the first calendar quarter after the moratorium period, the Secretary shall implement the revised quality control systems under title XIX, and shall reduce payments to States—

“(A) for quarters after the moratorium period in accordance with the restructured quality control systems; and

“(B) for quarters in and before the moratorium period, as provided under the regulations described in paragraph (1)(B).

“(d) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986].”

EFFECTIVENESS OF LAWS LIMITING FEDERAL FINANCIAL PARTICIPATION WITH RESPECT TO ERRONEOUS PAYMENTS MADE BY STATES UNDER A STATE PLAN APPROVED UNDER THIS SUBCHAPTER

Pub. L. 97-248, title I, §133(c), Sept. 3, 1982, 96 Stat. 374, provided that: “No provision of law limiting Federal financial participation with respect to erroneous payments made by States under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations), other than the limitations contained in section 1903 of such Act [42 U.S.C. 1396b], shall be effective with respect to payments to States under such section 1903 for quarters beginning on or after October 1, 1982, unless such provision of law is enacted after the date of the date of the enactment of this Act [Sept. 3, 1982] and expressly provides that such limitation is in addition to or in lieu of the limitations contained in section 1903 of the Social Security Act.”

MEDICAID PAYMENTS FOR INDIAN HEALTH SERVICE FACILITIES TO BE PAID ENTIRELY BY FEDERAL FUNDS; EXCLUSION OF PAYMENTS TO STATES IN COMPUTATION OF TARGET AMOUNT OF FEDERAL MEDICAID EXPENDITURES

Pub. L. 97-92, §§102, 118, Dec. 15, 1981, 95 Stat. 1193, 1197, as amended by Pub. L. 97-161, Mar. 31, 1982, 96 Stat. 22, provided, for the period Dec. 15, 1981, to not later than Sept. 30, 1982, that: “Notwithstanding section 1903(s) of the Social Security Act [42 U.S.C. 1396b(s)], all medicaid payments to the States for Indian health service facilities as defined by section 1911 of the Social Security Act [42 U.S.C. 1396j] shall be paid entirely by Federal funds, and notwithstanding section 1903(t) of the Social Security Act [42 U.S.C. 1396b(t)], all medicaid payments to the States for Indian health service facilities shall not be included in the computation of the target amount of Federal medicaid expenditures.”

PROMULGATION OF REGULATIONS FOR IMPLEMENTATION OF AMENDMENTS BY SECTION 17 OF PUB. L. 95-142

Pub. L. 95-142, §17(e)(2), Oct. 25, 1977, 91 Stat. 1202, required Secretary of Health, Education, and Welfare to

establish regulations, not later than 90 days after Oct. 25, 1977, to carry out amendments made by section 17 (amending sections 1395b-1 and 1396b of this title). See section 1302 of this title.

DEFERRAL OF IMPLEMENTATION OF DECREASES IN MATCHING FUNDS

Pub. L. 95-59, §6, June 30, 1977, 91 Stat. 255, provided that: “Notwithstanding the provisions of subsection (g) of section 1903 of the Social Security Act [42 U.S.C. 1396b(g)], the amount payable to any State for the calendar quarters during the period commencing April 1, 1977, and ending September 30, 1977, on account of expenditures made under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], shall not be decreased by reason of the application of the provisions of such subsection with respect to any period for which such State plan was in operation prior to April 1, 1977.”

COMPREHENSIVE CARE AND SERVICES FOR ELIGIBLE INDIVIDUALS BY JULY 1, 1977; REQUIREMENT INAPPLICABLE FOR ANY PERIOD PRIOR TO JULY 1, 1971; REGULATIONS; ADVICE TO STATES

Pub. L. 91-56, §2(b), Aug. 9, 1969, 83 Stat. 99, which provided that subsection (e) of this section was inapplicable to the period prior to July 1, 1971, and which authorized the Secretary to issue regulations, was repealed by Pub. L. 92-603, title II, §230, Oct. 30, 1972, 86 Stat. 1410.

EXEMPTION OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM FROM LIMITATIONS ON FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE

Pub. L. 90-248, title II, §248(d), Jan. 2, 1968, 81 Stat. 919, provided that: “The amendment made by section 220(a) of this Act [amending this section] shall not apply in the case of Puerto Rico, the Virgin Islands, or Guam.”

NONDUPLICATION OF PAYMENTS TO STATES; LIMITATION ON INSTITUTIONAL CARE

Pub. L. 89-97, title I, §121(b), July 30, 1965, 79 Stat. 352, as amended by Pub. L. 92-603, title II, §249D, Oct. 30, 1972, 86 Stat. 1429, provided that: “No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act [42 U.S.C. 1396 et seq.], or for any period after December 31, 1969. After the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.] for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX.”

§ 1396b-1. Payment adjustment for health care-acquired conditions

(a) In general

The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for appli-