of section 1903 of the Social Security Act [42 U.S.C. 1396b(g)], the amount payable to any State for the calendar quarters during the period commencing April 1, 1977, and ending September 30, 1977, on account of expenditures made under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], shall not be decreased by reason of the application of the provisions of such subsection with respect to any period for which such State plan was in operation prior to April 1, 1977.''

COMPREHENSIVE CARE AND SERVICES FOR ELIGIBLE INDIVIDUALS BY JULY 1, 1977; REQUIREMENT INAPPLICABLE FOR ANY PERIOD PRIOR TO JULY 1, 1971; REGULATIONS; ADVICE TO STATES

Pub. L. 91–56, § 2(b), Aug. 9, 1969, 83 Stat. 99, which provided that subsection (e) of this section was inapplicable to the period prior to July 1, 1971, and which authorized the Secretary to issue regulations, was repealed by Pub. L. 92–603, title II, § 230, Oct. 30, 1972, 86 Stat. 1410.

EXEMPTION OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM FROM LIMITATIONS ON FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE

Pub. L. 90–248, title II, § 248(d), Jan. 2, 1968, 81 Stat. 919, provided that: ''The amendment made by section 220(a) of this Act [amending this section] shall not apply in the case of Puerto Rico, the Virgin Islands, or Guam.''

NONDUPLICATION OF PAYMENTS TO STATES; LIMITATION ON INSTITUTIONAL CARE

Pub. L. 89–97, title I, § 121(b), July 30, 1965, 79 Stat. 352, as amended by Pub. L. 92–603, title II, § 249D, Oct. 30, 1972, 86 Stat. 1429, provided that: ''No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act [42 U.S.C. 1396 et seq.], or for any period after December 31, 1969. After the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.] for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX.''

### § 1396b–1. Payment adjustment for health care-acquired conditions

#### (a) In general

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

#### (b) Health care-acquired condition

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

#### (c) Medicare provisions

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

(Pub. L. 111–148, title II, § 2702, Mar. 23, 2010, 124 Stat. 318.)

#### Editorial Notes

REFERENCES IN TEXT

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

CODIFICATION

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

### § 1396c. Operation of State plans

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

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

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

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

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

**Editorial Notes**

CONSTITUTIONALITY

For constitutionality of section 121(a) of Pub. L. 89–97, amending this section, see Congressional Research Service, The Constitution of the United States of America: Analysis and Interpretation, Table of Laws Held Unconstitutional in Whole or in Part by the Supreme Court.

### § 1396d. Definitions

For purposes of this subchapter—

**(a) Medical assistance**

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

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1)[1] of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1396r–6 of this title,

(x) individuals described in section 1396a(u)(1) of this title,

(xi) individuals described in section 1396a(z)(1) of this title,

(xii) employed individuals with a medically improved disability (as defined in subsection (v)),

(xiii) individuals described in section 1396a(aa) of this title,

(xiv) individuals described in section 1396a(a)(10)(A)(i)(VIII) or 1396a(a)(10)(A)(i)(IX) of this title,

(xv) individuals described in section 1396a(a)(10)(A)(ii)(XX) of this title,

(xvi) individuals described in section 1396a(ii) of this title, or

(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,

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

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (*l*)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (*l*)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (*l*)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3)(A) other laboratory and X-ray services; and

(B) in vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such in vitro diagnostic products;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and[2] (D) counseling and pharmacotherapy for cessation

[1] See References in Text note below.

[2] So in original. The word ''and'' probably should not appear.