Nos. 17-17501 & 17-17502

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

B.K. by her next friend Margaret Tinsley, et al., Plaintiffs/Appellees, v. Gregory McKay, in his official capacity as Director of the Arizona Department of Child Safety, and Thomas J. Betlach, in his official capacity as Director of the Arizona Health Care Cost Containment System, Defendants/Appellants.	District Court No. 2:15-CV-00185-PHX-ROS

APPELLANTS' JOINT OPENING BRIEF

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JURISDICTIONAL STATEMENT

Plaintiffs sought class certification for claims brought "pursuant to 42 U.S.C. § 1983 to redress violations of the United States Constitution and the provisions of the federal Medicaid Act[.]" ER02701. The district court had federal-question jurisdiction under 28 U.S.C. §§ 1331 and 1343.

The district court granted class certification on September 30, 2017. ER00022-23. Defendants filed timely petitions for permission to appeal pursuant to Federal Rule of Civil Procedure ("Rule") 23(f) on October 16, 2017. This Court granted permission to appeal on December 19, 2017. ER00024-25. This Court has appellate jurisdiction under 28 U.S.C. § 1292(e) and Rule 23(f). *Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1186 (9th Cir. 2001).

ISSUES PRESENTED

1. Class certification under Rule 23(a)(2) requires questions of law or fact common to the class. The Complaint alleges a diverse assortment of "systemic" child welfare shortcomings, none of which affect all class members or identical subsets of class members. Did the district court err by finding commonality where the classes necessarily include thousands of uninjured members, members whose claims differ or conflict, and members whose injuries are not attributable to Defendants?
2. Rule 23(a)(3) requires representative parties to show their claims typify claims of the class. The Complaint alleges several unrelated child welfare

shortcomings. No class representative is affected by all alleged shortcomings, and many class members are unaffected by *any* alleged shortcoming. Did the district court err by finding typicality?

3. Rule 23(b)(2) requires a defendant to have acted or refused to act on grounds that apply generally to the class, enabling a court to construct a specific injunction under Rule 65(d) respecting the class as a whole. The district court determined that the class members' divergent, unrelated claims, and qualitatively different harms, are nevertheless remediable by one injunction because Rule 23(b)(2) contemplates class certification in "civil rights cases," and because Plaintiffs purportedly challenge a "common set of policies and practices." The Order does not distinguish types of civil rights cases and does not identify a unifying policy or practice. Did the district court contravene Rule 23(b)(2) because Plaintiffs' claims cannot be remedied in a single injunction? If so, did the district court also ensure that any potential injunction would exceed the court's remedial authority?

4. Rule 23(a) requires class representatives to *prove* they have standing and satisfy commonality and typicality. The district court certified the Medicaid Subclass based merely on *allegations* and without evidence that any purported practice actually violated the Medicaid statutes or that either class representative was denied Medicaid services. Did the district court err in certifying the Medicaid Subclass?

Pursuant to Ninth Circuit Local Rule 27-2.7, each of the statutes, regulations, and rules cited in this Brief is set forth in full in the concurrently-filed Addendum.

STATEMENT OF THE CASE

The Arizona Department of Child Safety (DCS) and the Arizona Health Care Cost Containment System (AHCCCS) provide welfare and healthcare services for approximately 14,300[1] Arizona foster children, including the Named Plaintiffs, who are in DCS's custody.[2] There were 18,000[3] Arizona foster children less than three years ago, in the wake of a tumultuous economic downturn that fractured family relationships and created a historic increase in removals to DCS custody.

Plaintiffs filed this class action lawsuit in February 2015,[4] just as DCS and AHCCCS faced the greatest strain on their finite resources. The Second Amended Complaint ("the Complaint") alleged substantive due process violations and statutory Medicaid violations[5] based on disputed deficiencies in such unrelated areas as dental

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[1] DCS Monthly Operational Report (Mar. 23, 2018), row 105, column Y, *available at* https://dcs.az.gov/content/dcsmonthly-operational-outcome-report-mar-2018 (last accessed April 29, 2018, as were all other websites cited in this brief).

[2] AHCCCS is the State's Medicaid agency.

[3] The number was 17,438 and growing in February 2015 when this lawsuit was filed. ER00514.

[4] Arizona Governor Doug Ducey appointed Defendant McKay as DCS Director one week after Plaintiffs filed the original complaint. *Governor Doug Ducey Announces Management Changes at Department of Child Safety* (Feb. 10, 2015), *available at* https://azgovernor.gov/governor/news/governor-doug-ducey-announces-management-changes-department-child-safety.

[5] Children in foster care are eligible for certain Medicaid services. 42 U.S.C. § 1396a(a)(10)(A)(i)(I). 42 U.S.C. § 1396, *et seq.* is referred to herein as the "Medicaid

care, investigations of maltreatment, overuse of group homes and separating siblings. ER02720-21, ER02729-30, ER02732, ER02735, ER02738.

The Complaint sought class certification under Rule 23(b)(2). ER02746. The proposed class and subclasses include a "General Class" consisting of *all* children who are or will someday be in DCS custody. ER02698. The "Medicaid Subclass"—members of the General Class who are eligible for Medicaid—is only slightly smaller, and the "Non-Kinship Subclass"—those not placed with a relative after DCS removes them—includes about half of all foster children. ER02727, ER02735. The Complaint does not and could not truthfully allege that all class members have been harmed or face imminent harm beyond the fact that they are all in DCS's legal custody. Instead, Plaintiffs contend that all present and future Arizona foster children face a *risk* of harm based on various deficiencies alleged in the Complaint, regardless of whether a particular deficiency has affected or will affect a given class member. ER02726.

The Complaint seeks declaratory and injunctive relief, but its request for relief does not identify an unlawful policy. *See* ER02727, ER02731, ER02735, ER02741,

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statutes" or "Medicaid Act." To receive Medicaid funds, states must provide, among other services, an Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") program. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B). That program must include periodic screening services, vision services, dental services, hearing services, and other services necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services[]." 42 U.S.C. § 1396d(r). States must furnish Medicaid assistance "with reasonable promptness." 42 U.S.C. § 1396a(a)(8); *see also* 42 C.F.R. § 435.930(a).

ER02746-48. Instead, it broadly and vaguely seeks an order "[p]ermanently enjoin[ing] DCS … and AHCCCS from subjecting plaintiffs to practices that violate their rights" and providing "appropriate remedial relief" to ensure Defendants' "future compliance with their legal obligations to plaintiffs including but not limited to" "establish[ing] and implement[ing] practices to ensure" the various "services to which they are entitled" under the Fourteenth Amendment and the Medicaid statute. ER02747.

Plaintiffs moved for class certification on November 29, 2016. *See* ER02539-84. Defendants opposed certification. *See* ER00572-99 (DCS), ER00143-59 (AHCCCS). Ten months later, without an evidentiary hearing or findings of fact, the district court issued an order certifying the General Class and the two Subclasses identified above.[6] ER00001-23 ("the Order"). Relying on *Parsons v. Ryan*, 754 F.3d 657 (9th Cir. 2014) ("*Parsons I*"), the Order rejected Defendants' arguments that the General Class and Subclasses lacked commonality and typicality, and that injunctive relief could not remediate alleged harms to the classes as a whole because there is no government act or refusal to act that applies generally to all class or subclass members.

This Court granted Defendants' timely petitions to review the Order under Rule 23(f) on December 19, 2017, *see* ER00024-25, and subsequently consolidated the appeals for review on the merits.

[6] Although the Order purports to grant the class certification motion "in part," it appears to grant the motion entirely. ER00022.

SUMMARY OF ARGUMENT

Class certification determinations under Rule 23(b)(2) are perilous because an insufficiently rigorous analysis, as occurred here and in *Parsons I*, impermissibly expands "[t]he scope of injunctive relief" beyond "the extent of the violation established," eroding the case or controversy requirement and inviting judicial encroachment into matters of executive and legislative policy. *Lewis v. Casey*, 518 U.S. 343, 359 (1996). This sort of faulty analysis binds together those who have colorable claims with those who do not; treats dissimilar and even conflicting claims as common; gives control to plaintiffs who do not typify other class members; and creates injunctions that cannot relieve any injury to the class as a whole.

Parsons I certified a class consisting of every inmate in Arizona's prison system, expanding the limits of commonality and the composition of the "class as a whole" beyond the bounds of Rule 23 as interpreted in *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011). Here, relying on *Parsons I*, the district court sanctioned similarly impermissible, sweepingly broad classes. For example, the General Class includes thousands of members who were not harmed and never faced an immediate risk of serious harm. The types of risk the district court identified are qualitatively different and unrelated to one another. And no policy or practice "glue" binds the class members' injuries to the same agency action or inaction. The same flaws exist in the two Subclasses.

In *Wal-Mart*, the plaintiffs "wish[ed] to sue about literally millions of employment decisions at once[,]" 564 U.S. at 352, and here Plaintiffs wish to sue about literally thousands of healthcare and placement decisions at once. Neither case has a common policy that causes the same injury to all class members and binds its members together. Class members lack the cohesion that allows for indivisible relief, and some individual, competing interests contradict other individual interests of class members altogether. No single injunction could remediate the unrelated alleged harms for class members as a whole.

Parsons I eroded class certification to the point where case-or-controversy principles collapse, the rationale for classwide adjudication dissolves, and crafting workable injunctions becomes impossible. This appeal provides an opportunity to correct that mistake and prevent its recurrence.

STANDARD OF REVIEW

This Court reviews challenges to class certification for abuse of discretion. *Abdullah v. U.S. Sec. Assocs. Inc.*, 731 F.3d 952, 956 (9th Cir. 2013). "A district court abuses its discretion if it (1) relies on an improper factor, (2) omits a substantial factor, or (3) commits a clear error of judgment in weighing the correct mix of factors." *Id.* "[A]n error of law is a per se abuse of discretion." *Id.* However, because class certification turns largely on questions of law, abuse of discretion review in class-certification cases "does not differ greatly from review for error." *Abrams v. Interco, Inc.*, 719 F.2d 23, 28 (2d Cir. 1983).

Some cases suggest courts should "accord the district court noticeably more deference" when reviewing *grants* of class certification than when reviewing *denials* of class certification. *E.g.*, *Wolin v. Jaguar Land Rover N. Am., LLC*, 617 F.3d 1168, 1171 (9th Cir. 2010) (citing *In re Salomon Analyst Metromedia Litig.*, 544 F.3d 474, 480 (2d Cir. 2008)). Those cases inadvertently misapply Judge Friendly's opinion in *Abrams*. *Abrams* held that "[a]buse of discretion can be found far more readily on appeals from the denial *or* grant of class action status than where the issue is, for example, the curtailment of cross-examination or the grant or denial of a continuance." 719 F.2d at 28 (emphasis added). *Abrams* reasoned that "courts have built a body of case law with respect to class action status[,]" and "a court of appeals can no more tolerate divergence by a district judge from the principles it has developed on this subject than it would under a standard of full review[.]" *Id.* So, unless the class certification ruling rests largely "on determinations of fact" or relies on a district judge's special experience, "review of class action determinations for 'abuse of discretion' does not differ greatly from review for error." *Id.*

In *Robidoux v. Celani*, another Second Circuit panel reviewed a denial of class certification and, citing *Abrams*, stated that "abuse of discretion can be found more readily on appeals from the denial of class status than in *other areas*…." 987 F.2d 931, 935 (2d Cir. 1993) (*per curiam*) (emphasis added). "Other areas" in *Abrams* meant areas *unrelated to class actions*. But in *Lundquist v. Sec. Pac. Auto. Fin. Servs. Corp.*, another Second Circuit panel misread *Robidoux* (and transitively *Abrams*) to mean that appellate

courts "are noticeably less deferential to the district court when that court has denied class status than when it has certified a class[.]" 993 F.2d 11, 14 (2d Cir. 1993). *Lundquist* thus unwittingly departed from *Robidoux* and *Abrams* and misconstrued *Robidoux* as heightening review only of a district court's *denial* of class certification. *Cf. Brown v. Electrolux Home Prods.*, 817 F.3d 1225, 1233 (11th Cir. 2016) (citing *Abrams* as Judge Friendly wrote it: "abuse of discretion is a continuum, and in the context of class actions, review for abuse of discretion often does not differ greatly from review for error") (internal citation and quotations).

Lundquists's error later propagated to this Court.[7] This Court should eschew that error now and apply the heightened review standard intended by *Abrams*, 719 F.2d at 28.

ARGUMENT

"The class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Comcast Corp. v. Behrend*, 569 U.S. 27, 33 (2013) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 700-701 (1979)). Accordingly, a class certification movant "must affirmatively demonstrate his compliance with [Rule 23.]" *Wal-Mart,* 564 U.S. at 350. "[P]laintiffs wishing to

[7] *See Wolin*, 617 F.3d at 1171 (Ninth Circuit), citing *In re Salomon*, 544 F.3d at 480 (Second Circuit), citing *Heerwagen v. Clear Channel Commc'ns*, 435 F.3d 219, 225 (2d Cir. 2006), citing *Parker v. Time Warner Entm't Co. L.P.*, 331 F.3d 13, 18 (2d Cir. 2003), quoting *Caridad v. Metro-North Commuter R.R.*, 191 F.3d 283, 291 (2d Cir. 1999), quoting *Lundquist*, 993 F.2d at 14.

proceed through a class action must actually prove—not simply plead—that their proposed class satisfies each requirement of Rule 23[.]" *Halliburton Co. v. Erica P. John Fund, Inc.*, 134 S. Ct. 2398, 2412 (2014). Every putative class must withstand a "rigorous analysis" of Rule 23(a)'s requirements: numerosity, commonality, typicality and adequacy. *Comcast*, 569 U.S. at 33 (quotations omitted).

This Court misapplied these principles in *Parsons I* and the district court—hewing to *Parsons I*—misapplied them here.

I. PLAINTIFFS' SPRAWLING SUPER-CLASSES LACK COMMONALITY.

A. *The contours of commonality under Rule 23(a)(2).*

The district court erred in finding commonality under Rule 23(a)(2), which requires "questions of law or fact common to the class[.]" "An individual question is one where members of a proposed class will need to present evidence that varies from member to member, while a common question is one where the same evidence will suffice for each member to make a prima facie showing or the issue is susceptible to generalized, class-wide proof." *Tyson Foods, Inc. v. Bouaphakeo*, 136 S. Ct. 1036, 1045 (2016) (brackets and quotations omitted).

Rule 23(a)(2) "is easy to misread, since 'any competently crafted class complaint literally raises common questions.'" *Wal-Mart*, 564 U.S. at 349 (quoting Richard A. Nagareda, *Class Certification in the Age of Aggregate Proof*, 84 N.Y.U. L. REV. 97, 131-32 (2009)) (brackets omitted). Reciting common questions is therefore "not sufficient to obtain class certification." *Id.* Nor is it sufficient merely to allege plaintiffs "have all

suffered a violation of the same provision of law." *Id.* at 350. Instead, "[c]ommonality requires the plaintiff to demonstrate that the class members have suffered the same injury" in a concrete way. *Id.* at 349-50 (quotations and citation omitted).

The class members' claims must also "depend upon a common contention … capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Id.* at 350. Accordingly, "[w]hat matters to class certification is not the raising of common 'questions'—even in droves—but, rather the capacity of a classwide proceeding to generate common *answers* apt to drive the resolution of the litigation. Dissimilarities within the proposed class are what have the potential to impede the generation of common answers.'" *Id.* (quoting Nagareda, *supra*, at 132) (ellipses omitted).

Wal-Mart demonstrates that a showing of common *answers* is crucial where the underlying injury arises in a multitude of differing circumstances. A common answer is the glue holding together the alleged reason(s) why the class members' claims arose. No glue binds the different, unrelated circumstances here.

B. *The certified classes include thousands of members who have not been injured.*

"Commonality requires the plaintiff to demonstrate that the class members 'have suffered the same injury.'" *Id.* at 349-50 (quoting *Gen. Tel. Co. of Sw. v. Falcon*,

457 U.S. 147, 157 (1982)). That assumes putative class members have been "injured" in the first place, so "a class should not be certified if it is apparent that it contains a great many persons who have suffered no injury at the hands of the defendant[.]" *Kohen v. Pacific Inv. Mgmt. Co. LLC & PIMCO Funds*, 571 F.3d 672, 677 (7th Cir. 2009). The Supreme Court reiterated the point recently, remanding a case to "consider whether a Rule 23(b)(2) class action continues to be the appropriate vehicle for respondents' claims in light of [*Wal-Mart*]" because "some members of the certified class may not be entitled to [relief] as a constitutional matter." *Jennings v. Rodriguez*, 138 S. Ct. 830, 852 (2018).

Commonality thus also implicates Article III standing, although the point where lack of commonality defeats standing remains unclear. Some cases suggest *all* class members must have standing before a class action may proceed. *E.g.*, *Mazza v. Am. Honda Motor Co., Inc.*, 666 F.3d 581, 594 (9th Cir. 2012). Others suggest it need only "be possible that class members have suffered injury, not that they did suffer injury, or that they must prove such injury at the certification phase." *Torres v. Mercer Canyons Inc.*, 835 F.3d 1125, 1137 n.6 (9th Cir. 2016). Still others suggest that "[i]n a class action, standing is satisfied if at least one named plaintiff meets the requirements." *Bates v. United Parcel Serv., Inc.*, 511 F.3d 974, 985 (9th Cir. 2007) (*en banc*).

The soundest approach requires *all* class members to have standing. Article III requires "an injury in fact" which is "actual or imminent, not conjectural or

hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (quotations and citations omitted). And "Article III does not give federal courts the power to order relief to any uninjured plaintiff, class action or not." *Tyson*, 136 S. Ct. at 1053 (Roberts, C.J., concurring); *Shady Grove Orthopedic Assocs., P.A. v. Allstate Ins. Co.*, 559 U.S. 393, 408 (2010) ("A class action, no less than traditional joinder ... merely enables a federal court to adjudicate claims of multiple parties at once, instead of in separate suits. And like traditional joinder, it leaves the parties' legal rights and duties intact and the rules of decision unchanged."); *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 613 (1997) ("Rule 23's requirements must be interpreted in keeping with Article III constraints, and with the Rules Enabling Act, which instructs that rules of procedure 'shall not abridge, enlarge or modify any substantive right[.]'") (quoting 28 U.S.C. § 2072(b)); *Avritt v. Reliastar Life Ins. Co.*, 615 F.3d 1023, 1034 (8th Cir. 2010) ("A class must therefore be defined in such a way that anyone within it would have standing[;] ... a named plaintiff cannot represent a class of persons who lack the ability to bring a suit themselves.") (quotations omitted); *In re Deepwater Horizon*, 732 F.3d 326, 341 (5th Cir. 2013) (opinion of Clement, J.) ("By including claimants in the class definition that lack colorable claims, a court ... ignores the standing requirement of Article III and creates a substantive right where none existed before."). Regardless, even under the broadest conception of standing, Rule 23 independently precludes class certification "if the definition is so broad that it sweeps within it persons who could not have been injured by the defendants' conduct," or "if it is apparent that it contains a great many

persons who have suffered no injury[.]" *Kohen*, 571 F.3d at 677; *see also Jennings*, 138 S. Ct. at 852 (*Wal-Mart's* statement that "'Rule 23(b)(2) applies only when a single injunction or declaratory judgment would provide relief to each member of the class'" implicates decertification because "some members of the certified class may not be entitled to" relief).

Here, examining the elements of the substantive due process claims raised by the General Class and Non-Kinship Subclass reveals the problems with certifying a class when many of its members suffer no concrete and particularized harm. Due process requires state authorities to provide foster children with "reasonable safety and minimally adequate care[.]" *Tamas v. Dep't. of Soc. & Health Servs.*, 630 F.3d 833, 842 (9th Cir. 2010). This prohibits the state from "act[ing] with such deliberate indifference to the liberty interest that their actions shock the conscience[,]" *id.* at 844 (quotations omitted), but it does not "take aspirational statutory, regulatory, and private standards as to a variety of topics within the overall complex of foster child care and convert each of them to constitutional requirements," *Connor B. ex rel. Vigurs v. Patrick*, 774 F.3d 45, 55 (1st Cir. 2014) (footnote omitted).

Substantive due process claims require two showings. *Tamas*, 630 F.3d at 844. The *mens rea* is "deliberate indifference," a "state of mind more blameworthy" than even "gross negligence." *Farmer v. Brennan*, 511 U.S. 825, 834 (1994); *Tamas*, 630 F.3d at 844 n.10. A plaintiff must show "'that the officials were subjectively aware of facts from which an inference could be drawn that a substantial risk of serious harm

existed' and (a) 'the official actually drew that inference' or (b) 'that a reasonable official would have been compelled to draw that inference.'" *Henry A. v. Willden*, 678 F.3d 991, 1001 (9th Cir. 2012) (quoting *Tamas*, 630 F.3d at 845). The second showing is "an objectively substantial risk of serious harm," *Tamas*, 630 F.3d at 845, that would result "in the denial of the minimal civilized measure of life's necessities," *Farmer*, 511 U.S. at 834 (quotations and citation omitted). The harm must either *occur* or be substantial and imminent. *Id.* at 845-46. The imminent and substantial showings mirror the standing requirement. "[Plaintiffs] who have suffered, or will *imminently* suffer, *actual* harm" get relief; it is not the role of courts, but that of the political branches, to shape the institutions of government in such fashion as to comply with the laws and the Constitution." *Casey*, 518 U.S. at 349 (emphasis added).

Here, the General Class and Non-Kinship Subclass have thousands of members who have not suffered and will not suffer cognizable harm. Plaintiffs generally allege that provision of physical, dental, and mental healthcare systems is insufficient; that DCS "overuse[s]" congregate care and has an inadequate array of foster care placements; that DCS caseloads are "excessive"; and that DCS fails to complete investigations in a sufficiently timely manner. *See* ER00014-15, ER00018-19 (summarizing Plaintiffs' claims). But Plaintiffs could not deny that for thousands of children in Arizona's foster care system, Defendants *succeed* in delivering adequate or better care, and no substantial risk of serious harm ever presents itself.

For instance, Plaintiffs assert that as of 2013, "DCS failed to properly assess and address the children's physical health needs in a third (34%) of the cases reviewed[,]" and that "22% of children who had been in foster care for more than 12 months had not received a comprehensive physical health examination." ER02723. Even if these disputed figures were true in 2013 and remained true at the time the district court certified the class in late 2017 (and they were not), it would mean the vast majority of children who are now class members *did* receive timely and adequate health assessments and examinations. And it would mean that a *greater* number of class members faced no harm—let alone substantial and imminent risk of serious harm—based on the timeliness or adequacy of well-child checkups (EPSDT examinations). Allegations about untimely physical health examinations under the EPSDT schedule, with no corresponding evidence that the timing of a particular medical service was unreasonable under the circumstances, cannot establish imminent risk of serious harm to *any* individual (let alone to an entire class).

Examples of class members who face no common injury or no injury at all abound. Temporary placement in congregate care does not establish any imminent risk of harm. Children in kinship care do not need a greater array of foster homes. The great majority of siblings were placed together (and never at risk of separation, if that could constitute imminent, serious harm). *See* ER00896.

The same is true of the statutory claim behind the Medicaid Subclass. For example, Plaintiffs allege that, during fiscal year 2012, "36% of children in state foster

care ages three to six did not receive well-care visits required under the periodicity schedule that the state is required to establish under the EPSDT provisions of the federal Medicaid Act." ER02724. And they acknowledge that not all members of the Medicaid Subclass have been denied EPSDT services. ER02729 (alleging AHCCCS has a practice of failing to "provide members of the Medicaid Subclass" with EPSDT services, not *all* members of the Subclass). Thus, thousands of Medicaid Subclass members *are* provided EPSDT services, and promptly so.

The Order nevertheless certified a "General Class" composed of *all* "children who are or will be in the legal custody of DCS due to a report or suspicion of abuse or neglect"; a "Non-Kinship Subclass" containing *all* of the many thousands of "members in the General Class who are not placed in the care of an adult relative or person who has a significant relationship with the child"; and a "Medicaid Subclass" nearly as large as the general class containing *all* members of the General Class entitled to EPSDT services under the federal Medicaid statute. ER00022-23. This approach *ensures* that *thousands* of uninjured foster children will be members of the certified classes, as well as many more who have not all "suffered *the same* injury." *Wal-Mart*, 564 U.S. at 350 (emphasis added).

Applying *Parsons I* and echoing its statements, the district court treated *attenuated* risk of *any* potential injury as legally cognizable. "Any one child," the court wrote, "could easily fall ill, be injured, need treatment, require a diagnostic [*sic*], need emergency care, crack a tooth, or require mental health treatment," and "any child in

the foster care system would be subjected to the DSC's [*sic*] policies regarding placement decisions." ER00016-17. *Cf. Parsons I*, 754 F.3d at 678 (applying similar reasoning in the prison context). This directly conflicts with *Casey*: "The actual-injury requirement would hardly serve [its] purpose … if once a plaintiff demonstrated harm from one particular inadequacy in government administration, the court were authorized to remedy *all* inadequacies in that administration. The remedy must of course be limited to the inadequacy that produced the injury in fact that the plaintiff has established." 518 U.S. at 357.

As *Parsons I* erred, so did the court below, basing commonality on the false conclusion that "every single child in the foster care system faces a *substantial* risk of *serious* harm if DSC [*sic*] policies and practices[8] fail to adhere to constitutional requirements," thus effectively eliminating the substantial and imminent requirements. *Id.* at 17 (emphases added). *Cf. Parsons I*, 754 F.3d at 678-79. The district court separately found that the Medicaid claims were "common" because the Complaint alleged that they were. *See* ER00017-19. As explained below, *see* Section IV(B), *infra*, that reasoning was also mistaken.

Parsons I correctly identified a risk all prisoners faced: falling ill and receiving inadequate care. But that risk was not uniformly substantial or imminent among *all* prisoners. The greater the attenuation, the further the court strays from commonality.

[8] The court never identified such "policies and practices." *See* Section I(D), *infra*.

And although there is no precise point when risk gains or loses the "substantial" and "imminent" characteristics, the Supreme Court has determined that merely being subject to an allegedly inadequate government system does *not* pose a cognizable "imminent" or "substantial" risk:

> The requirement that an inmate ... must show actual injury derives ultimately from the doctrine of standing, a constitutional principle that prevents courts of law from undertaking tasks assigned to the political branches.... [T]he distinction between the two roles would be obliterated if, to invoke intervention of the courts, no actual or imminent harm were needed, *but merely the status of being subject to a governmental institution that was not organized or managed properly.* If ... a healthy inmate who had suffered no deprivation of needed medical treatment were able to claim violation of his constitutional right to medical care ... simply on the ground that the prison medical facilities were inadequate, the essential distinction between judge and executive would have disappeared: it would have become the function of the courts to assure adequate medical care in prisons.

Casey, 518 U.S. at 349-50 (emphasis added; citations omitted). *Parsons I* did precisely what the above-quoted passage from *Casey*, and the holding in *Estelle v. Gamble*, 429 U.S. 97, 104 (1976), prohibited. *Parsons v. Ryan*, 784 F.3d 571, 572 (9th Cir. 2015) ("*Parsons II*") (Ikuta, J., dissenting from denial of rehearing *en banc* [hereafter "Ikuta, J., dissenting"]).

Casey made the point unequivocally: "an inmate cannot establish relevant actual injury simply by establishing that his prison's law library or legal assistance program is subpar in some theoretical sense." 518 U.S at 351. "That," the Court continued, "*would be the precise analog of the healthy inmate claiming constitutional violation because of the inadequacy of the prison infirmary*." *Id.* (emphasis added). Both are analogs to a well-

adjusted foster child claiming a constitutional or Medicaid violation based on untimely behavioral examinations. A plaintiff "must go one step further and demonstrate that the alleged shortcomings" actually caused injury or presented a substantial risk of serious injury. *Id.* Plaintiffs do not take this necessary step: thousands of uninjured class members claim constitutional and statutory violations based only upon generalized allegations of inadequacies in the system.

Neither *Parsons I* nor the Order refer to *Casey*, but they are legally indistinguishable on this point.[9] Rule 23 cannot extend jurisdiction to class members who lack standing or constitutional injury. *See Connor B.*, 774 F.3d at 55 ("The assertion also fails that the present deficiencies mean that the children are exposed to an incrementally greater risk of future harm, and harm of constitutional dimensions. That there may be deficiencies yet to be fully addressed does not establish that there has been a constitutionally cognizable increased risk of class-wide harm[.]"); *see also* 28

[9] *Parsons I* inappropriately relied instead on *Brown v. Plata*, 563 U.S. 493 (2011), as permitting class actions based on "systemic, future-oriented" claims challenging "systemwide deficiencies" in care. *Parsons I*, 754 F.3d at 677. But "*Plata* involved the certification of two discrete classes: those prisoners with 'serious mental disorders,' and those with 'serious medical conditions.'" *Parsons II*, 784 F.3d at 578 (Ikuta, J., dissenting)). "These discrete classes may have [had] sufficiently similar serious medical needs to meet the standard ... in a way the" omnibus classes in *Parsons* (and the classes here) did not. *Id.* And *Plata* was not a class certification case. It addressed whether the lower court "exceeded its authority in issuing a remedial order under the Prison Litigation Reform Act ... in two consolidated cases[,]" one "in which the state conceded that deficiencies in prison medical care violated prisoners' Eighth Amendment rights." *Id.* (Ikuta, J., dissenting) (quotations omitted). *Plata* did not *approve* the classes certified there and therefore cannot support the certification analysis in *Parsons I*.

U.S.C. § 2072(b); Rule 82; *Tyson*, 136 S. Ct. at 1053 (Roberts, C.J., concurring); *Shady Grove*, 559 U.S. at 408; *Amchem*, 521 U.S. at 613. Even if it could, "[c]ommonality requires the plaintiff to demonstrate that the class members 'have suffered the same injury.'" *Wal-Mart*, 564 U.S. at 349-50 (quoting *Falcon*, 457 U.S. at 157); *see also Jennings*, 138 S. Ct. at 852; *Kohen*, 571 F.3d at 677. That commonality is absent here.

Accordingly, even taking Plaintiffs' factual assertions as true, the certified classes include thousands of members who have suffered no injury or constitutionally cognizable *threat* of injury under *Casey*, and the classes are fatally overbroad. *Parsons I*'s contrary holding is "at odds with the binding authority of the Supreme Court," and must be overruled. *Parsons II*, 784 F.3d at 573 (Ikuta, J., dissenting). The Order rests squarely on the infirm part of *Parsons I* and should be vacated. ER00016-17.

C. *The issues in this case cannot be resolved "in one stroke" because thousands of class members possess different claims, conflicting claims, or no claims at all.*

The classes here would lack commonality even if they were not overbroad. All class members must suffer the same injury *and* present a common contention "capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 564 U.S. at 350. That commonality makes possible "'common *answers* apt to drive the resolution of the litigation.'" *Id.* (quoting Nagareda, *supra*, at 132) (emphasis included).

The district court concluded that this case presents "common questions capable of resolution on a classwide basis." ER00015. But the court's articulation of the "common questions" reveals widely different, unrelated, and inconsistent harm or risks of harm, none of which were tethered to any identified policy (much less the same policy). Plaintiffs allege constitutionally inadequate care and Medicaid violations in areas ranging from emergency shelters to dental examinations. ER00014-15.

Even if these were "common questions," they lack the *common answers* Rule 23(a)(2) requires. *Wal-Mart*, 564 U.S. at 350. "[W]hat really matters to class certification" is "not similarity at some unspecified level of generality but, rather, dissimilarity that has the capacity to undercut the prospects for joint resolution of class members' claims through a unified proceeding." Nagareda, *supra*, at 131. It is therefore not enough merely to ask whether the defendant "fulfill[ed]" its "obligations" because, "while that generic question is surely a part of [the plaintiffs'] claims, it must be answered separately for each child based on individualized questions of fact and law, and the answers are unique to each child's particular situation." *Jamie S. v. Milwaukee Pub. Schs.*, 668 F.3d 481, 498 (7th Cir. 2012).

The "answer" to inadequate dental care or delayed EPSDT services has nothing to do with improving the timeliness of investigations, and reducing caseworker workloads does nothing to eliminate a purported shortage of foster homes. This alone demonstrates the lack of commonality. *See id.*; *Lightfoot v. D.C.*, 273 F.R.D. 314, 326 (D.D.C. 2011) (plaintiffs cannot "conflate a wide variety of

practices and impute them to the class as a whole by collecting them under a single, unilluminating umbrella of 'systemic' failures"; "[u]nder Plaintiffs' approach, certification would be appropriate in virtually all actions ... so long as the putative class, through artful pleading, states the challenged 'policy or custom' with sufficient generality[]"); *cf. M.D. ex rel. Stukenberg v. Perry*, 675 F.3d 832, 844 (5th Cir. 2012) (classes which attempt "to aggregate several amorphous claims of systemic or widespread conduct into one 'super-claim'" "stretch the notions of commonality" and should not be certified unless it can be "precise[ly]" explained "how the resolution of those claims will resolve an issue that is central to the validity of each of the individual class member's claims in one stroke") (quotations omitted).

And the "answer" to one claim may divert resources that could "answer" another claim. A child may have a strong interest in developing additional behavioral health resources, but no interest in developing additional dental care resources. That conflict thwarts a chief purpose of commonality: "ensuring that absentee members are fairly and adequately represented." *Walters v. Reno*, 145 F.3d 1032, 1045 (9th Cir. 1998).

The General Class and Subclasses even advance claims which *conflict* with other class claims. The "Non-Kinship Subclass," for instance, alleges that DCS places too many children in congregate care instead of foster homes and "improperly separates children from siblings." ER00015. But sometimes the only way to keep siblings

together is to place them in congregate care. Plaintiffs' claims are thus often unsusceptible to common answers even *as to an individual child*.

What the court inaccurately described as a risk of harm attributable to unidentified "statewide policy and practices" was actually "a smorgasbord of day-to-day, case-by-case operational failures ... as opposed to the state's implementation of any specific policy uniformly affecting—and injuring—each child." *M.D.*, 675 F.3d at 846. Those claims require individualized inquiries; there is no "common contention" whose "truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 564 U.S. at 350. That would require at least some showing of "a common *pattern and practice* that could affect the class as a whole." *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 983 (9th Cir. 2011) (emphasis altered). "If there is no evidence that the entire class was subject to the same ... practice, there is no question common to the class." *Id.*; *see also DL v. D.C.*, 713 F.3d 120, 126 (D.C. Cir. 2013) ("In the absence of identification of a policy or practice that affects all members of the class in the manner *Wal-Mart* requires, the district court's analysis is not faithful to the Court's interpretation of Rule 23(a) commonality.").

Instead of a rigorous effort to identify a policy that inflicted a classwide injury, the district court lumped disparate claims together because they all derive from the Fourteenth Amendment, ER00015, or "the federal Medicaid statute," ER00014. The court's statement that it would "discuss [Plaintiffs' substantive due process] claims *together* when analyzing the commonality prerequisite," ER00014 (emphasis added),

demonstrates the inappropriate generality of this inquiry. Then the search for common answers devolved to "whether DCS's practices subject the General Class to a substantial risk of harm in violation of Fourteenth Amendment rights," ER00015, and "whether practices by DSC [sic] and AHCCCS failed to adhere to the Medicaid statute," ER00018.

That is no classwide, single-stroke resolution. "Commonality requires the plaintiff to demonstrate that the class members have suffered the *same injury*." *Wal-Mart*, 564 U.S. at 349-50 (emphasis added; quotations and citation omitted). It does not mean, as the district court determined, "*merely that they have all suffered a violation of the same provision of law*." *Id.* at 350 (emphasis added). "After *Wal-Mart* it is clear that defining the class by reference to [a] pattern and practice of failing to provide [services] speaks too broadly because it constitutes only an allegation that the class members 'have all suffered a violation of the same provision of law[.]'" *DL*, 713 F.3d at 126; *see also Jamie S.*, 668 F.3d at 497 ("That all the class members have 'suffered' as a result of disparate individual ... violations is not enough; it does not establish that the individual claims have any question of law or fact in common."). Even before *Wal-Mart*, it was insufficient to "simply point[] to a general area" such as "the provision of mental health services, where [the defendant] may need improvement" rather than "identifying a specific policy or practice that affects all class members in accordance with Rule 23." *Stevens v. Harper*, 213 F.R.D. 358, 382 (E.D. Cal. 2002).

Needed improvements "should be considered by the state legislature and by state administrators[,]" not courts. *Id.*

The district court's cursory consideration of commonality as to the Medicaid claims created additional error. By presuming, without analysis, that *Parsons I* applies to Medicaid claims, it imported an element of risk into the Medicaid claim that does not exist. Even *Parsons I* recognized that its commonality conclusion turned on "the nature of the plaintiffs' claims." 754 F.3d at 678; *see also Jimenez v. Allstate Ins. Co.*, 765 F.3d 1161, 1165 (9th Cir. 2014) (commonality "necessarily depends on the nature of the underlying legal claims that the class members have raised"). The characteristic (and "constitutional injury") common to all of the inmate class members in *Parsons I* was an element unique to their Eighth Amendment claim: "their alleged exposure … to a substantial risk of serous future harm to which the defendants are allegedly deliberately indifferent." 754 F.3d at 678; *see Farmer*, 511 U.S. at 834. But that is *not* an element of Plaintiffs' Medicaid claim. *See* 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); *see generally Katie A., ex rel. Ludin v. Los Angeles Cnty.*, 481 F.3d 1150, 1158 (9th Cir. 2007) (describing elements without reference to risk exposure). Thus, the Eighth Amendment "glue" in *Parsons I* does not bind the members of the Medicaid Subclass. The district court committed reversible error in assuming it did.

Commonality would also have stalled under a faithful adherence to *Wal-Mart*. "[T]he answers to the common [Medicaid] questions could hardly be more individualized." *D.B. ex rel. M.M. v. Dreyfus*, No. 11-CV-2017 RBL, 2012 WL 1821241,

at *3 (W.D. Wash. May 18, 2012). Did Defendants make the Medicaid service available to the class member? Did the class member request the service? Was the service actually provided? Was it provided in a timely manner? Or was there some reason beyond Defendants' control that caused the delay or denial? These questions cannot be resolved as to every single Medicaid Subclass member in a single stroke.

D. *Treating alleged deficiencies as "statewide policies and practices" corrupted the analysis of commonality and cohesion.*

Conflating a common legal theory with commonality itself, the district court erroneously presumed that "specified statewide policies and practices" exposed all foster children to a substantial risk of harm. ER00016. But the court never identified a "policy" or "practice" it could strike down.

Proof that a system fails to work as intended does not establish a common question for purposes of class certification. *See DL*, 713 F.3d at 126 ("After *Wal-Mart* it is clear that defining the class by reference to the District's pattern and practice of failing to provide [services] speaks too broadly[.]"); *Jamie S.*, 668 F.3d at 498 (plaintiffs cannot show commonality merely by pointing to disparate "systemic failures"); *J.B. ex rel. Hart v. Valdez*, 186 F.3d 1280, 1289 (10th Cir. 1999) (plaintiffs cannot satisfy Rule 23(a) merely by "attempt[ing] to broadly conflate a variety of claims to establish commonality through amorphous allegations of 'systematic failures[]'"); *Lightfoot*, 273 F.R.D. at 325-26 (plaintiffs must identify the offending policy or custom and demonstrate it is common to the class); *see also Jamie S.*, 668 F.3d at 504 (Rovner, J.,

concurring in part and dissenting in part) (*Wal-Mart* forbids "an effort to sweep many individual plaintiffs and sets of facts into one class on the premise that all reflect illegal conduct by the defendant in practice and culture if not in policy"). The district court's certification rests on nothing more than disputed allegations that Arizona's child welfare and Medicaid systems sometimes do not work as well as intended. The Order refers to agency "policies" 25 times,[10] but it describes only conditions, not formal or informal policy. Likewise, it refers to agency "practices" 38 times[11] but identifies no approved or tacitly approved practice.

The lack of an identifiable policy makes this case an ill fit for class certification (and for injunctive relief at all). Anecdotal allegations of deficient care untethered to *policies* cannot establish the substantive due process element of *deliberate* indifference. And an injunction cannot alleviate harm that the enjoined party never created. If a policy *creates* an unlawful condition, enjoining its enforcement can alleviate the condition. But substandard care *not* caused by deliberate action or inaction is simply a condition.

The distinction between an unconstitutional *act* and an undesirable *condition* separates actionable violations from legal nullities. The Eighth Amendment cases provide a fitting analog: "[t]he Eighth Amendment does not outlaw cruel and unusual 'conditions'; it outlaws cruel and unusual 'punishments.'" *Farmer*, 511 U.S. at 837.

[10] *See* ER00003, ER00006, ER00012, ER00015-21.
[11] *See* ER00003, ER00006, ER00012, ER00014-21.

Only the latter is deliberate. Likewise, substantive due process prohibits *deliberate* indifference, not inadequacy. *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir. 2006) (deliberate indifference requires a "purposeful act" and resulting harm).

Identifying a specific offending DCS or AHCCCS policy is the necessary predicate for displacing Arizona's policymaking authority. In cases seeking injunctive relief from unconstitutional prison conditions, both before and after *Wal-Mart*, courts have found commonality among prisoners who first identified and challenged the same specific, written, acknowledged, official policies. *See*, *e.g.*, *Logory v. Cnty. of Susquehanna*, 277 F.R.D. 135, 142 (M.D. Pa. 2011) (common "delousing procedure[]"); *Bumgarner v. N.C. Dep't of Corr.*, 276 F.R.D. 452, 456-57 (E.D.N.C. 2011) (common sentencing-credit programs); *Tyler v. Suffolk Cnty.*, 253 F.R.D. 8, 10 (D. Mass. 2008) (common "system of bathroom access"); *Hilton v. Wright*, 235 F.R.D. 40, 52 (N.D.N.Y. 2006) (common policy regarding eligibility for Hepatitis C treatment).[12]

[12] These cases also refute the misplaced concern in *Parsons I* that "systemwide" problems would go unaddressed without sweeping class remedies. *See* 754 F.3d at 680. Class certification remains appropriate where a single policy simultaneously endangers numerous plaintiffs. *See id.* at 678 (collecting cases involving unsafe drinking water, heat exposure, asbestos, and substandard fire prevention); *Parsons II*, 784 F.3d at 581 (Ikuta, J., dissenting) (district courts may certify "separate classes or subclasses" in cases involving common "policies and practices"). Individual plaintiffs who bring claims under 42 U.S.C. § 1983 are further "entitled to relief that will redress any discrete wrong done them …without certifying a class." *Rahman v. Chertoff*, 530 F.3d 622, 627 (7th Cir. 2008). "Decisions favorable to particular plaintiffs will have their effect in the normal way: through the force of precedent." *Id.*

The Order also indiscriminately attributed capacity limitations to unidentified statewide "practices"—as if Defendants strive to be short-staffed or to deliver inadequate or delayed services. It is not DCS *practice* to place a child in congregate care, for example, unless it is the least restrictive available placement under the circumstances.[13] DCS cannot be simultaneously striving to improve conditions and deliberately indifferent to the same conditions. *Cf. Liebe v. Norton*, 157 F.3d 574, 579 (8th Cir. 1998) ("[T]he County's policy cannot be both an effort to prevent suicides and, at the same time, deliberately indifferent to suicides."). Judicial intervention would merely displace one *constitutional* policy with another.

Parsons I similarly conflated a deficiency with a "policy" or "practice," holding that all plaintiffs "set forth numerous common contentions whose truth or falsity c[ould] be determined in one stroke: whether the specified statewide policies and practices to which they are all subjected by ADC expose them to a substantial risk of harm." 754 F.3d at 678. It then stated "[t]he district court identified 10 statewide ADC policies and practices to which all members of the class are subjected" and which formed the "glue" that held the case together. *Id.*

But many of those "policies" were described only as a "[f]ailure to provide" timely access to health care and sufficient health care staffing. *Parsons v. Ryan*, 289 F.R.D. 513, 522-23 (D. Ariz. 2013) (internal citations omitted). A failure is not a

[13] ER02366-78. The current version of the same policy is available at https://dcs.az.gov/content/dcsselecting-out-home-care-provider.

policy or practice creating an issue common to all class members under Rule 23(a)(2). Nor are such failures an "act or refusal to act" under Rule 23(b)(1). An untimely EPSDT service could result from factors beyond Defendants' control, such as medical contraindications that prohibit "make up" immunizations for children who did not receive certain shots by certain ages before they came into care. These are unrelated to policy. Plaintiffs presented no common question the court could have answered with injunctive relief, much less answered indivisibly in a single injunction. *See Parsons II*, 784 F.3d at 577, 579 (Ikuta, J., dissenting). These classes should have failed.

Absent a statewide policy or practice that causes or approves, for example, the overuse of congregate care, no "one stroke" can indivisibly relieve all class members of purportedly unnecessary congregate care. Treating "overuse" of congregate care (ER00015, ER00017) as an unconstitutional *practice* is like saying it is the Navy's "practice" to run ships aground. It sometimes happens, but it is only a *practice* when the alternative is to scuttle the ship, collide with another vessel, or suffer some other worse event. A judicial prohibition against running ships aground might sound systemic and specific, but it would not change a policy or lessen a risk.

E. *The district court presumed that aggregate statewide statistics demonstrated commonality in circumstances where only case-by-case inquiries could establish a constitutional or Medicaid violation.*

The district court erroneously concluded this case "does not require the [c]ourt to determine the effect of the policies and practices upon any individual class member (or class members) or to undertake an individualized determination." ER00016. As discussed above, child welfare and healthcare determinations are *inherently* individualized and cannot be evaluated solely in the aggregate. For example, all agree that kinship placements are generally better than non-kinship placements, but "[t]o the extent that children are not placed with their kin, it is in part because not all children have kin with whom they could properly be placed, particularly in light of the other factors (like those related to child safety) which bear on the placement decision." *Connor B.*, 774 F.3d at 59. "Indeed, it would be irresponsible … to provide family access in certain situations." *Id.* Only individualized inquiries can reveal a violation of minimum constitutional standards. The district court's reliance on aggregate statistics despite the inherently individualized inquiries in child welfare cases underscores the flaws in its commonality analysis.

Most fundamentally, using aggregate statistics to prove *commonality* is circular:

> The sort of statistical evidence that plaintiffs present has the same problem as the statistical evidence in *Wal-Mart*: it begs the question. Plaintiffs' expert ... assumed that the appropriate unit of analysis is all of [the defendant's] Chicago-area sites. He did not try to demonstrate that proposition. If [the defendant] had 25 superintendents, 5 of whom discriminated in awarding overtime, aggregate data would show that black workers did worse than white workers—but that result would not imply that all 25 superintendents behaved similarly, so it would not demonstrate commonality.

Bolden v. Walsh Constr. Co., 688 F.3d 893, 896 (7th Cir. 2012); *see also* Nagareda, *supra*, at 125-30 (discussing the "troubling circularity" of class certification arguments which "presuppose[] the very aggregate unit whose propriety the court is to assess").

Plaintiffs create the same false construct here, using a statewide statistical analysis to purportedly find aggregate deficiencies in care; and then presuming the problem results from statewide policies and practices. For example, DCS case workers have lower caseloads in some regions and higher caseloads in others. *See* ER02558. Aggregating the data produces a statewide caseload average that Plaintiffs allege is too high. *Id.* Then they ascribe the high average to a *statewide* policy or practice that would cause high caseloads in *all* regions. *Id.* at 20. This aggregation conflates conditions with policies.

Because *aggregate problems* do not necessarily have a *common cause* (much less a common *solution*), merely showing aggregate problems is "insufficient to establish that [a plaintiff's] theory can be proved on a classwide basis." *Wal-Mart*, 564 U.S. at 356; *see also DL*, 713 F.3d at 128 (under *Wal-Mart*, violating duties does not establish Rule 23(a) commonality absent a uniform policy or practice that affects all class members). "'[I]nformation about disparities at the regional and national level does not establish the existence of disparities at individual stores, let alone raise the inference that a company-wide policy of discrimination is implemented by discretionary decisions at the store and district level.'" *Wal-Mart*, 564 U.S. at 356-57 (quoting *Dukes v. Wal-Mart*

Stores, Inc., 603 F.3d 571, 637 (9th Cir. 2010) (*en banc*) (Ikuta, J., dissenting)). This Court has previously recognized that aggregation promotes a false inference:

> Whether gender disparities are confined to only two regions of Costco's eight regions, for example, addresses precisely the question of whether there are common questions of law and fact among the putative class members. If, as Plaintiffs allege, promotion decisions are based on the biased attitudes of the CEO and upper management, one would expect disparities in all, or at least most, regions. A disparity in only 25% of the regions, however, would not show that "discrimination manifested itself in ... promotion practices in the same general fashion," *Wal-Mart*, [564 U.S. at 353], throughout Costco—which is necessary to show commonality in a nationwide class. If no such nationwide discrimination exists, Plaintiffs would face an exceedingly difficult challenge in proving that there are questions of fact and law common to the nationwide class.

Ellis, 657 F.3d at 983-84.[14]

Moreover, aggregate statistics can only demonstrate correlation and therefore cannot show *deliberate* indifference. Statistics proving that children in Colorado's foster care system suffer higher-than-average skiing accidents, or that Florida's congregate care population increases after a devastating hurricane, do not establish "deliberate indifference" in their child welfare systems. So too in Arizona, where children might be placed further from home on average than children in other states because Arizona's vast, sparsely populated regions drive the average distance upward. Arizona's child welfare officials did not become "deliberately indifferent" when a

[14] And aggregating statistics such as national averages does not establish a constitutional standard. "[B]eing in the bottom of a list of states, without more," does not "provide[] strong evidence of a constitutional violation." *Connor B.*, 774 F.3d at 56 n.14. "Once a list is established, there is always someone at the bottom." *Id.*

tumultuous economic downturn precipitated a *doubling* of children in Arizona's foster care system in just six years. Without a common policy binding all claims together, the only way to know if purportedly "systemic" disparities arose from deliberate indifference—and not some other cause—is by examining *each case individually*. *Cf. Wal-Mart*, 564 U.S. at 367 (courts may not take a "sample set of the class members" and use it to extrapolate to the class as a whole; such a "novel project" would deprive the defendant of its right to litigate statutory defenses to individual claims).

Then-Judge Alito made the same point in *Rouse v. Plantier*, 182 F.3d 192 (3rd Cir. 1999). The right "to be free from deliberate indifference to his or her serious medical needs," he observed, "is one that obviously varies depending on the medical needs of the particular prisoner." *Id.* at 199. "Consequently, it is possible that conduct that violates the Eighth Amendment rights of [some] plaintiffs may not violate the constitutional rights of [other] plaintiffs." *Id.* *Rouse* "recognized that a different level of care was due to each group of diabetic prisoners to avoid violating their Eighth Amendment rights, and required the district court to carefully calibrate what would constitute deliberate indifference as to each subclass of prisoner[.]" *Parsons II*, 784 F.3d at 580 (Ikuta, J., dissenting). "In light of [*Wal-Mart*], the approach adopted by *Rouse* is correct, and the approach adopted by the panel" in *Parsons I*, and the district court in this case, "is not." *Id.* at 581.

II. NO PLAINTIFF COULD TYPIFY MEMBERS OF SUCH SPRAWLING CLASSES.

The circumstances that defy commonality also defy typicality. Class certification requires that "the claims or defenses of the representative parties are typical of the claims or defenses of the class." Rule 23(a)(3). The purpose of this requirement "is to assure that the interest of the named representative aligns with the interests of the class." *Stearns v. Ticketmaster Corp.*, 655 F.3d 1013, 1019 (9th Cir. 2011). "The test of typicality is whether other members have the same or similar injury, whether the action is based on conduct which is not unique to the named plaintiffs, and whether other class members have been injured by the same course of conduct." *Wolin*, 617 F.3d at 1175.[15] This inquiry overlaps and tends to merge with the commonality inquiry. *Wal-Mart*, 564 U.S. at 349 n.5.

Plaintiffs could not possibly demonstrate typicality. The claims allege unrelated failings spanning the spectrum of Arizona's foster-care system. ER00015-18. Neither B.T., B.K., nor any class member could be "typical" in these circumstances. The diversity of claims means class members have not all "been injured by the same

[15] Some Ninth Circuit cases apply a "permissive standard[]"—unique to this Court—that treats representative claims as typical if they are "reasonably coextensive" with those of absent class members. *Torres*, 835 F.3d at 1141. This misguided approach originated in *Hanlon v. Chrysler Corp.*, 150 F.3d 1011, 1019-20 (9th Cir. 1998), without citations or analysis. Typicality ensures that the named plaintiffs faithfully represent the interests of the class, and "careful attention" to the typicality requirement is therefore "indispensable." *See Falcon*, 457 U.S. at 157. Without true typicality, representative plaintiffs do not adequately represent the interests of absent class members.

course of conduct." *Wolin*, 617 F.3d at 1175. Interests that differ and even conflict preclude a finding that any one plaintiff's interests could align with all others.

Rule 23 further requires Plaintiffs to "*prove* that the[y] are *in fact*" typical of the class; a "mere pleading" is not sufficient. *Wal-Mart*, 564 U.S. at 350-51 (emphasis added). "The class determination generally involves considerations that are enmeshed in the factual and legal issues comprising the plaintiff's cause of action." *Falcon*, 457 U.S. at 160 (quotations omitted). The Order, however, defies *Wal-Mart* by relying solely on the Complaint's allegations:

> Here, B.T. and B.K. are children in DSC [sic] custody. It is *alleged* that both of them have been and are exposed to a substantial risk of serious harm by the challenged DSC [sic] and AHCCCS policies and practices. Thus, the Named Plaintiffs *allege* "the same or [a] similar injury" as the rest of the putative class; they *allege* this injury is a result of a course of conduct that is not unique to any of them and the injury follows from the cause of conduct at the center of the class claims.

ER00019 (emphasis added).

Many of the allegations repeated in the Court's Order are disputed (e.g., *compare* ER00010, *with* ER02709, *and* ER02666-67) or irrelevant (e.g., events going back to 2006). Some of the Order's factual assertions are absent from the Complaint altogether (e.g., that BT was denied EPSDT services numerous times [*see* ER00009, which lacks a citation to the record in support of this factual assertion]). Others still are demonstrably false. For example, the Order relies upon an allegation in the Complaint that BK remained in a group home for more than two years after re-entering DCS custody (*see* ER00008) even though Plaintiffs' own expert report

confirms that BK was transferred to a therapeutic family foster home (an "HCTC") within 7 months of her removal (*see* Doc. No. 392-2, at 9).[16] These sorts of errors underscore why Rule 23 requires *evidence*, not allegations. The district court's misplaced reliance on disputed allegations directly contravened *Wal-Mart*, 564 U.S. at 350-51, and constituted an abuse of discretion as a matter of law, *Abdullah*, 731 F.3d at 956.

The Order further presumes that allegations of undefined deficiencies such as "overuse" of "congregate care" are assessable under some established standard Defendants fail to meet. But, as DCS's expert stated in a report appended to DCS's opposition to class certification, there is no universally accepted definition of "congregate care"; different states (and different experts) define that term in different ways.[17] Plaintiffs also rely on "congregate care" statistics which include large numbers of children whose presence in congregate care is not attributable to DCS or who are not in DCS custody in the first place, including 18-to-20-year-olds, children in custody of other agencies, and hospitalized children. ER02148. Using such terms to express

[16] The district court did not consider this report because it was not completed until *after* the court had already granted class certification. But that merely proves Defendants' point. *Wal-Mart* requires class-certification decisions to be supported by actual evidence. *See* 564 U.S. at 350-51. The fact that the district court certified the classes *before the relevant evidence had been gathered* only underscores its mistaken approach.
[17] In Texas, for example, a "congregate care facility" is one that "contain[s] 13 or more children." *M.D. v. Abbott*, 152 F. Supp. 3d 684, 692-93 (S.D. Tex. 2015). Under that definition, Arizona's "use of congregate care" would shrink considerably.

findings means nothing without definitions because States can define or even ignore these terms as they please.

The district court also erred by defining typicality at such a high level of generality as to render it meaningless:

> Since every child in the foster care system under state custody is highly likely to require medical care and housing placement, each Named Plaintiff is similarly positioned to all other children with respect to exposure to the Defendants' policies and practices.

ER00019. Even *Parsons I*, limited to forms of health care, was narrower. *See* 754 F.3d at 662. Plaintiffs challenge qualitatively different components of Arizona's foster care system—health care, dental care, mental health care, sibling placement, congregate placement, caseworker caseloads, inter-agency coordination, and so on. Class members affected by one operation may seek to remedy their own injuries while ignoring (or even harming) interests of other members. The more potential disagreements there are, the less typical the class representatives become, and the less appropriate the case is for class certification.

III. THE ORDER VIOLATES RULES 65(B) AND 23(B)(2).

The injunction contemplated by the Order, to the extent it is discernable, necessarily violates Rules 65(b) and 23(b)(2) because it cannot afford the same relief to members of the General Class and Subclasses as a whole. The Order strays from

the "paradigm" of Rule 23(b)(2) classes,[18] in which one unconstitutional policy was directed categorically at a group that spoke with one voice and sought one remedy. The contours of the class and the injunction should be self-evident in Rule 23(b)(2) cases. Here, they are not.

A. *The Order, shaped by* Parsons I*, contravenes the purpose and intent of Rule 23(b)(2).*

Rule 23(b)(2) permits class certification where the requirements of Rule 23(a) are satisfied and "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." The Rule's drafters "intended to reach situations" where "final relief of an injunctive nature or of a corresponding declaratory nature" will "settl[e] the legality of the *behavior* with respect to the class as a whole." Rule 23(b)(2) advisory committee's note (1966) (emphasis added). "In particular, the Rule reflects a series of decisions involving challenges to racial segregation—conduct that was remedied by a single classwide order." *Wal-Mart*, 564 U.S. at 361; *accord* Rule 23(b)(2) advisory committee's note (1966) ("Illustrative are various actions in the civil-rights field where a party is charged with discriminating unlawfully against a class, usually one whose members are incapable of

[18] *Dukes*, 603 F.3d at 645 (*en banc*) (Ikuta, J., dissenting) (quotations omitted), *rev'd*, 564 U.S. 338.

specific enumeration."). The 1966 Advisory Committee's Note cites eight examples of such cases, all addressing school desegregation.

Because Rule 23(b)(2) draws directly on these historical antecedents, "[c]ourts considering whether to certify a class under [Rule 23(b)(2)] must take the prudent course of staying close to the historical model and traditional paradigm as understood by the Advisory Committee in drafting the rule." *Dukes*, 603 F.3d at 645 (*en banc*) (Ikuta, J., dissenting) (quotations omitted), *rev'd*, 564 U.S. 338; *see also Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 842 (1999) (applying the same "prudent" approach to Rule 23(b)(1), which was similarly drafted based on a "historical model").

Under this framework, Rule 23(b)(2) permits class certification—as in the school desegregation cases—"only when a single injunction or declaratory judgment would provide relief to each member of the class." *Wal-Mart*, 564 U.S. at 360. That rule applies because "[w]hen a class seeks an indivisible injunction benefitting all its members at once, there is no reason to undertake a case-specific inquiry[.]" *Id.* at 362. Conversely, the rule "does not authorize class certification when each individual class member would be entitled to a *different* injunction or declaratory judgment against the defendant." *Id.* at 360.

Wal-Mart's admonition does not require every member of the class to show injury at the class-certification stage. A class is certifiable under Rule 23(b)(2) even if the policy in question "has taken effect or is threatened only as to one or a few members of the class, provided it is based on grounds which have general application

to the class." Rule 23(b)(2) advisory committee's note (1966). But it requires focus on the *remedy* for any potential injury. "The key to the (b)(2) class is 'the indivisible nature of the injunctive or declaratory remedy warranted—the notion that the conduct is such that it can be enjoined or declared unlawful *only as to all of the class members or as to none of them*.'" *Wal-Mart*, 564 U.S. at 360 (quoting Nagareda, *supra*, at 132) (emphasis added).[19] That was the central Rule 23(b)(2) error below: the Order does not contemplate indivisible injunctive relief regarding the class *as a whole*.

B. *A court cannot issue a single, specific injunction because class members face different potential harms, require different remedies, and have competing interests.*

The Order certified three classes:

> General Class: All children who are or will be in the legal custody of DCS due to a report or suspicion of abuse or neglect.
>
> Non-Kinship Subclass: All members in the General Class who are not placed in the care of an adult relative or person who has a significant relationship with the child.
>
> Medicaid Subclass: All members of the General Class who are entitled to early and periodic screening, diagnostic, and treatment services under the federal Medicaid statute.

ER00022-23. These classes and the claims they press could hardly be broader.

[19] This is what preserves Article III standing in Rule 23(b)(2) classes even though class members need not show injury: the remedy *must necessarily* apply to all class members. An order striking down a discriminatory policy, for instance, *necessarily* benefits all members of the disfavored group, regardless of whether they suffered an actual injury.

The General Class potentially includes every child who lives—or ever will live—in the State of Arizona. If "[a] broader and more diverse group of claims seem[ed] difficult to contemplate" after *Parsons I*, *see Civil Rights Educ. & Enforcement Ctr. (CREEC) v. Hospitality Props. Trust*, 867 F.3d 1093, 1108 (9th Cir. 2017) (Morris, J., dissenting), the district court's certification order now makes such contemplation possible. Plaintiffs' allegations, as summarized by the district court, include:

- "failure to provide timely access to health care," including:
    - "comprehensive evaluations";
    - "timely annual visits";
    - "semi-annual preventative dental health care";
    - "adequate health assessments"; and
    - "complete immunizations";
- "failure to coordinate the delivery of physical and dental care services";
- "ineffective coordination and monitoring of physical and dental services by DCS";
- "DCS's overuse of congregate care for children with unmet mental health needs";
- "excessive DCS caseworker caseloads";
- "failure to initiate investigations in a timely manner after reports of abuse";
- "failure to document a timely 'safety assessment' after initiating an investigation";
- "failure to meet deadline[s] for closing investigations"; and

- "delays in important investigative steps."

ER00014-15. The diverse allegations regarding the Non-Kinship Subclass—including "excessive use of emergency shelters and group homes, unnecessary separation of siblings, and placement of children far from home" (ER00015)—and the Medicaid Subclass—including "AHCCCS' incomplete and out-of-date service plans" (ER00017)—are similarly far-ranging.

No "single injunction" could "provide relief to each member of" these classes. *Wal-Mart*, 564 U.S. at 360. Unlike the unitary injunctive relief in paradigmatic cases of racial discrimination, this case would require different types of relief for different class members. *Some* foster children require vaccinations. *Some* reside in *different* congregate care settings based on individual needs and circumstances and often unrelated to DCS policy or practice, such as hospitalization or juvenile delinquency proceedings. *Very few* experience maltreatment in care. The permutations are limitless. At most, if the individual plaintiffs sought injunctive relief separately, "each individual class member" might "be entitled to a *different* injunction or declaratory judgment against the defendant." *Id.*

Furthermore, no injunction could address every permutation and still comply with Rule 65(d)(1), which requires "[e]very order granting an injunction" to "state the reasons why it issued," "state its terms specifically," and "describe in reasonable detail—and not by referring to the complaint or other document—the act or acts

restrained or required." "Movants may not make an end-run around this rule by requesting an injunction that operates at some stratospheric level of abstraction." *Vallario v. Vandehey*, 554 F.3d 1259, 1268 (10th Cir. 2009) (quotations omitted). Plaintiffs must "give content" to the requested equitable relief, *id.*, and a request for "a bare injunction to follow the law" is insufficient, *CREEC*, 867 F.3d at 1103. "Rule 23(b)(2)'s bottom line, therefore, demands at the class certification stage [that] plaintiffs describe in reasonably particular detail the injunctive relief they seek such that the district court can at least conceive of an injunction that would satisfy [Rule 65(d)'s] requirements, as well as the requirements of Rule 23(b)(2)." *D.G. v. Devaughn*, 594 F.3d 1188, 1200 (10th Cir. 2010)) (quotations and citations omitted). The Order did not even *attempt* to explain what such an injunction would look like.

Nor did Plaintiffs, who have the burden to show their claims can be remedied in a "single stroke." *See Ellis*, 657 F.3d at 979-80. That requires them, in turn, to explain their desired relief *with specificity* so it may be determined whether an injunction "is appropriate respecting the class as a whole." Rule 23(b)(2). Plaintiffs merely asked the district court in this case to "enjoin [Defendants] from subjecting plaintiffs to practices that violate their rights" and to compel Defendants to "establish and implement" unspecified "practices" to meet constitutional standards. ER02747-48. That does not carry their burden. *See Lakeland Reg'l Med. Ctr. v. Astellas US, LLC*, 763 F.3d 1280, 1291 (11th Cir. 2014) (plaintiff failed "to affirmatively demonstrate that class certification was appropriate under Rule 23(b)(2)" because "it never identified

exactly what injunctive or declaratory relief it was seeking" and instead merely requested "such declaratory and injunctive relief as appropriate in order to compel and ensure [defendant's] future compliance with law.") (quotations omitted); *Vallario*, 554 F.3d at 1268 ("Respondents' class certification motion merely relies on the plea in their complaint for such 'declaratory and injunctive relief ... as the Court deems just.' ... In failing to require Respondents to carry their burden of showing such relief is plausible, the district court abused its discretion."); *Friedman v. Dollar Thrifty Auto. Grp.*, 304 F.R.D. 601, 614 (D. Colo. 2015) (plaintiffs failed to show relief that was "applicable to the entire class" because they submitted "no proposed injunction" and because their prayer for relief "[wa]s very general, and d[id] not specify the unlawful conduct" that occurred "on a class wide basis"); *Brown v. Kerkhoff*, 279 F.R.D. 479, 500 (S.D. Iowa 2012) (generic request for "sweeping reform" is insufficient).

Failing to define injunctive relief appropriate to the class as a whole would also cause the court to exceed its remedial authority upon finding a constitutional or statutory violation. If an injunction were to compel Defendants to act or refrain in ways that do not apply to all class members, a *de facto* right arises that no statute or constitutional provision recognizes. *See Deepwater Horizon*, 732 F.3d at 341-43 (opinion of Clement, J.) ("By including claimants in the class definition that lack colorable claims, a court ... ignores the standing requirement of Article III and creates a substantive right where none existed before."). It will also have failed to minimize interference with legitimate state activities in tailoring remedies. *See Stone v. City &*

Cnty. of San Francisco, 968 F.2d 850, 860 (9th Cir. 1992) (in fashioning remedial orders for state entities, "federal courts should exercise the least possible power adequate to the end proposed") (internal quotations omitted); *see also Casey*, 518 U.S. at 350 (the distinction between the judicial and executive branches "would be obliterated" if federal courts intervened simply because claimants were "subject to a governmental institution that was not organized or managed properly" without showing actual or imminent harm); *Rizzo v. Goode*, 423 U.S. 362, 379 (1976) (federal courts enjoining state entities must give "appropriate consideration … to principles of federalism in determining the availability and scope of equitable relief").

Plaintiffs' request for a "neutral expert monitor" to determine class-wide relief at some future date, *see* ER02747-48, highlights the impossibility of fashioning indivisible, classwide relief. Appointing a monitor does not provide final injunctive relief to any of the classes as a whole—it merely outsources the tailoring of *individual* relief. "[T]his kind of relief would be class-wide in name only, and it would certainly not be final." *Jamie S.*, 668 F.3d at 499. The district court abused its discretion by failing to require Plaintiffs to show how relief could be tailored—in a single injunction for the class as a whole—under Rules 23(b)(2) and 65(d)(1).

C. *Indivisible injunctive relief requires homogeneity among class members; otherwise, mandatory class participation under Rule 23(b)(2) is unfair to absent class members.*

The district court's unbounded class certification also raises serious fairness concerns for absent class members. Rule 23(b)(2) creates "mandatory classes[.]" *Wal-*

Mart, 564 U.S. at 362. Unlike classes certified for predominance and superiority under subsection 23(b)(3), Rule 23(b)(2) classes "provide[] no opportunity for ... class members to opt out, and do[] not even oblige the District Court to afford them notice of the action." *Id.* "The procedural protections attending the (b)(3) class—predominance, superiority, mandatory notice, and the right to opt out—are missing from (b)(2) not because the Rule considers them unnecessary, but because it considers them unnecessary *to a (b)(2) class*." *Id.* (emphasis in original). "When a class seeks an indivisible injunction benefitting all its members at once, there is no reason to undertake a case-specific inquiry into whether class issues predominate or whether class action is a superior method of adjudicating the dispute." *Id.* at 362-63. It is therefore "thought (rightly or wrongly) that notice has no purpose when the class is mandatory, and that depriving people of their right to sue in this manner complies with the Due Process Clause." *Id.* at 363.[20]

Accordingly, "the indivisible nature" of the relief is crucial. The cases contemplated by Rule 23(b)(2)'s drafters *should* be adjudicated at once because "the relief sought *must perforce* affect the entire class at once[.]" *Wal-Mart*, 564 U.S. at 361-62 (emphasis added). That fit was tight in cases challenging blanket policies of racial

[20] The "absence of notice and opt-out violates due process" if the class action "predominantly" seeks money damages. *Wal-Mart*, 564 U.S. at 363 (citing *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 812 (1985)). The Supreme Court has declined to address whether the same is true in class actions seeking only equitable relief. *See Phillips*, 472 U.S. at 811 n.3.

segregation; a facially discriminatory policy can be "'enjoined or declared unlawful only as to all of the class members or as to none of them.'" *Id.* at 360-61 (quoting Nagareda, *supra*, at 132). A court has no competing interests to balance if all class members are entitled to identical relief on equal footing.

Not so here. Reasonable people and *reasonable members of the class* can differ on the appropriateness of the remedy. Some would shift resources to investigations that others would shift to recruiting foster families or to opening field offices. Some would prioritize faster adoptions while others would prioritize lengthier investigations of potential adoptive families to ensure that children are not subjected to renewed maltreatment. Some would prioritize behavioral assessments while others would prioritize vision screenings. And many others would credit Defendants for performing capably and want them to stay the course.

These competing interests negate the rationale for class treatment. *Allison v. Citgo Petroleum Corp.* recognized an analogous problem in damages cases: "[B]ecause of the group nature of the harm alleged and the broad character of the relief sought, the (b)(2) class is, by its very nature, assumed to be a homogenous and cohesive group with few conflicting interests among its members. … The underlying premise of the (b)(2) class—that its members suffer from a common injury properly addressed by class-wide relief—begins to break down when the class seeks to recover back pay or other forms of monetary relief to be allocated based on individual injuries." 151 F.3d 402, 413 (5th Cir. 1998) (quotations omitted); *accord Allen v. Isaac*, 100 F.R.D. 373, 376-

77 (N.D. Ill. 1983). The same holds true in cases involving divisible *injunctive* relief: "Where a lead plaintiff seeks an equitable remedy that is divisible, mandatory class actions certified under Rule 23(b)(2) thus present the same risk that nonconsenting class members will be erroneously deprived of their control entitlement as is present in the case of mandatory class actions seeking only money damages." Ryan C. Williams, *Due Process, Class Action Opt Outs, and the Right Not to Sue*, 115 COLUM. L. REV. 599, 651-652 (2015).

If Plaintiffs prevail under the Order, the district court, or perhaps a monitor who answers to the court, will weigh these competing interests without input from absent class members. Absent class members will neither receive notice nor have opportunity to object to any settlement, remedy, or injunction. Yet if there is an actionable violation, the court's injunction will bind them all regardless of whether they believe it serves their interests. *See Wetzel v. Liberty Mut. Ins. Co.*, 508 F.2d 239, 248-49 (3d Cir. 1975) ("Because of the cohesive nature of the class, Rule 23(c)(3) contemplates that all members of the class will be bound.") (citations omitted). That flouts due process to absent members and shows why the indivisible nature of relief is the "key to the (b)(2) class" and why "the conduct is such that it can be enjoined or declared unlawful *only* as to all of the class members or as to none of them."' *Wal-Mart*, 564 U.S. at 360 (quoting Nagareda, *supra* at 132) (emphasis added).

With *Parsons I* as a blueprint, the district court avoided this limitation in two ways. It first focused on alleged *harms* to the exclusion of proposed *remedies*. The

district court decided Plaintiffs qualify for class treatment because they "challenge Defendants' common set of policies and practices involving health care services and the placement of children in the foster care system" instead of arguing "that a specific plaintiff should have received a particular diagnosis or treatment instead of another." ER00021. The court therefore reasoned that Rule 23(b)(2) certification was appropriate because "the harm Named Plaintiffs seek to remedy is the 'risk of exposure' created by subjecting children in foster care to DSC's [*sic*] and AHCCCS's policies and practices—not the harm an individual child suffers from a misdiagnosis." ER00021.

But Rule 23(b)(2) requires not that every class member suffered the same exposure to *harm* in some *abstract* sense, but rather that every class member is *necessarily* entitled to the same *relief* in a *concrete* sense:

> The insight of [Rule 23(b)(2)] is not simply that class treatment is appropriate when the defendant has engaged in a course of conduct that is similar at some unspecified level of generality. Rather, the crux of the rule in actual operation today consists of the indivisible nature of the injunctive or declaratory remedy warranted—the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them. Here, again, what matters is not similarity arising from the defendant's conduct but rather dissimilarity that has the capacity to undercut the indivisible character of an appropriate remedy.

Nagareda, *supra*, at 132; *accord Wal-Mart*, 564 U.S. at 360.

Plaintiffs cannot seek an unspecified "remedy" to systemic wrongs. They must affirmatively explain what that purported "remedy" will be, demonstrating that the

court can provide it "indivisibly" in "a single injunction" under Rule 65(d) and that it will "provide relief to each member of the class." *Wal-Mart*, 564 U.S. at 360. The Order erroneously excused Plaintiffs from that showing.

The district court's second critical error was finding that class certification was appropriate because "Rule 23(b)(2)'s primary role is the certification of civil rights cases *like this one*." ER00020 (emphasis added). Rule 23(b)(2) was drafted with school-desegregation cases in mind, *see Wal-Mart*, 564 U.S. at 361, but not all "civil rights" cases qualify under the rule, *see E. Tex. Motor Freight Sys. Inc. v. Rodriguez*, 431 U.S. 395, 405-06 (1977); *Vallario*, 554 F.3d at 1269 ("the simple fact that Respondents bring [a civil rights] suit does not establish that they have satisfied the provisions of Rule 23."). Rule 23(b)(2) applies only to cases where injunctive relief "is appropriate respecting the class as a whole," as it was in desegregation cases. It does not apply otherwise because it would deny due process to absent class members and exceed a federal court's remedial authority.

The Order cites two pre-*Wal-Mart* circuit-level decisions that suggest otherwise. ER00020-21 (citing *DG*, 594 F.3d at 1188, and *Marisol A. v. Guiliani*, 126 F.3d 372 (2d Cir. 1997) (*per curiam*)). *Marisol A.* is representative. In *Marisol A.*, the Second Circuit wrote that "civil rights cases seeking broad declaratory or injunctive relief for a large and amorphous class fall squarely into the category of 23(b)(2) actions" and suggested plaintiffs are entitled to Rule 23(b)(2) certification whenever they "seek injunctive relief" and "predicate the lawsuit on the defendants' acts and omissions with respect

to the class." 126 F.3d at 378 (quotations and ellipsis omitted). These cases cannot survive *Wal-Mart*.

Parsons I is the only post-*Wal-Mart* case regarding Rule 23(b)(2) cited in the Order. *Parsons I* acknowledges *Wal-Mart* but relies extensively on pre-*Wal-Mart* authority, *see* 754 F.3d at 686-89, and does not align with *Wal-Mart*'s underlying rationale. *Parsons I* tried to reconcile *Wal-Mart* with the facts presented by reasoning that "every inmate in the proposed class is allegedly suffering the same (or at least a similar) injury and that injury can be alleviated for every class member by uniform changes in statewide ADC policy and practice." 754 F.3d at 689. "For example," the court continued, "every inmate in ADC custody is allegedly placed at risk of harm by ADC's policy and practice of failing to employ enough doctors—an injury that can be remedied on a class-wide basis by an injunction that requires ADC to hire more doctors, with the exact number of necessary additional hires to be determined by the district court if, after a trial, it ultimately concludes that the defendants engaged in unlawful conduct." *Id.*

Wal-Mart, however, requires more than an alleged injury that *can* be remedied on a class-wide basis by an injunction. Rule 23(b)(2) applies to injuries that can *only* be remedied by a class-wide injunction: indivisible relief contemplates conduct that can be enjoined or declared unlawful "*only* as to all of the class members or as to none of them." *Wal-Mart*, 564 U.S. at 360 (emphasis added; quotations omitted). That requirement serves a critical purpose. Even accepting the dubious proposition that

"an injunction" to "hire more doctors" (with "the exact number" to be determined later) could satisfy the specificity requirements of Rule 65(d), reasonable class members could disagree about whether that *remedy* is the right one. Due process requires some mechanism for absent class members to voice that disagreement. The Order provides none.

D. *Providing injunctive relief to disjunctive, statewide classes displaces executive policymaking with judicial policymaking.*

Finally, treating multiple potential remedies as one unitary remedy pulls the court beyond its remedial authority and usurps the policymaking prerogatives of the political branches. If systemic change could be wrought in "one stroke" by one reasonably specific injunction, one would expect child welfare lawsuits to involve brief, discrete, targeted judicial oversight of a political branch's functions. But that has not happened.

"Running complex governmental social programs calls for management skills of a very high order" and "[s]igning a consent decree does not repeal this reality." Ross Shandler & David Schoenbrod, *From Status to Contract and Back Again: Consent Decrees in Institutional Reform Litigation*, 27 REV. LITIG. 115, 120 (2007). Judicial oversight can therefore remain in place for *decades* awaiting "systemic" improvement. *See, e.g.*, *LaShawn A. v. Gray*, Civ. A. No. 89-1754 (TFH) (D.D.C.) (case filed June 1989; judgment entered April 1991; system remains under judicial monitoring); *Juan F. v. Malloy*, No. 2:89 CV 859 (SRU) (D. Conn.) (case filed

December 1989; settlement reached January 1991; system remains under judicial monitoring).

Replacing generations of democratically accountable decision-makers with unaccountable judicial monitors erases "the essential distinction between judge and executive[.]" *Casey*, 518 U.S. at 350. "It is the role of courts to provide relief to claimants, in individual or class actions, who have suffered, or will imminently suffer, actual harm; it is not the role of courts, but that of the political branches, to shape the institutions of government in such fashion as to comply with the laws and the Constitution." *Id.* at 349.

Rightly so. "There are good reasons class-wide challenges to a state agency's entire set of practices for care of foster children are difficult to bring successfully." *Connor B.*, 774 F.3d at 55. "'[T]here certainly is no reason to think judges or juries are better qualified than appropriate professionals in administering an institution." *Id.* (quoting *Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982)). "Judicial review is" therefore "limited, to prevent interference by the federal judiciary with the internal operations of these institutions." *Id.* (quoting *Youngberg*, 457 U.S. at 322) (quotations omitted).

That limitation is particularly necessary here, where *Plaintiffs' attorneys concede* that, since they filed suit, Arizona has "made some changes, and by some measures, Arizona's foster care system has improved" and even become "commendable." Anne Ronan & Harry Frischer, *Your Turn: Arizona is neglecting its foster kids. Suing may be the*

only way to save them, ARIZONA REPUBLIC (Mar. 25, 2018), *available at* https://www.azcentral.com/story/opinion/op-ed/2018/03/26/arizona-foster-kids-lawsuit/439861002/.

Plaintiffs' concession demonstrates the inappropriateness of an injunction and attendant judicial oversight. Due process requires only that Defendants not "act with such deliberate indifference to the liberty interest that their actions shock the conscience." *Tamas*, 630 F.3d at 844. It "does not require that the defendants instantly fix all deficiencies in the foster care system." *Connor B.*, 774 F.3d at 56. Defendants may also "exercise professional judgment in ordering improvements over time, or in deciding which deficiencies to address first." *Id.* at 57. "To grant injunctive relief notwithstanding … concrete, good faith improvements is precisely the kind of substitution of judicial judgment for professional judgment that [Supreme Court precedent] prohibits, especially in light of the 'sensitive federalism concerns' at play in institutional reform litigation." *Id.* (quoting *Horne v. Flores*, 557 U.S. 433, 448 (2009)). That approach, embodied in the ruling challenged here, is irreconcilable with Rule 23(b)(2) and Rule 65(d).

IV. NAMED PLAINTIFFS FAILED TO PROVIDE PROOF OF STANDING, COMMONALITY, OR TYPICALITY AS TO THE ASSERTED MEDICAID SUBCLASS.

In addition to the flaws described above, Plaintiffs failed to carry their burdens to affirmatively prove standing, commonality, or typicality regarding their Medicaid claims.

A. *Plaintiffs did not prove standing.*

Because Defendant Betlach challenged the truth of Plaintiffs' standing allegations on the Medicaid claim, Plaintiffs had "an affirmative obligation to support [their] jurisdictional allegations with proof" they suffered an injury fairly traceable to the Medicaid violations they alleged. *NewGen, LLC v. Safe Cig, LLC*, 840 F.3d 606, 614 (9th Cir. 2016); *see also Casey*, 518 U.S. at 357 ("That a suit may be a class action … adds nothing to the question of standing, for even named plaintiffs who represent a class must allege and show that they personally have been injured, not that injury has been suffered by other, unidentified members of the class to which they belong and which they purport to represent.") (quotations and citation omitted).

Plaintiffs provided no evidence that Defendants violated the Medicaid Act with regard to the Named Plaintiffs, either by failing to provide EPSDT services or by doing do so without the required "reasonable promptness." The district court instead relied solely upon the Complaint's *allegations*, which the court erroneously treated as "facts," ER00009, ER00011, and "evidence," ER00012, that purportedly "indicate[d]" that the two Named Plaintiffs "suffered harm from not receiving a variety of health care services, . . . and from not receiving the EPDST [sic] services in a prompt manner" ER00009, ER00011. These conclusions have no evidentiary basis. They derive solely from the Complaint.

B. *Plaintiffs did not prove commonality and typicality.*

Similarly, the district court erred by analyzing commonality and typicality as if Rule 23 set forth a mere pleading standard. But *Wal-Mart* requires an affirmative demonstration "that there are *in fact* sufficiently numerous parties, common questions of law or fact, etc." 564 U.S. at 350 (emphasis in original). Furthermore, to certify a class based on a purported "general policy," there must be "significant proof" that a system-wide policy in fact exists. *Id.* at 353; *accord Jamie S.*, 668 F.3d at 498; *see also Thomasson v. GC Services Ltd. P'ship*, 539 F. App'x 809, 810 (9th Cir. 2013).

The district court started by noting Plaintiffs were not challenging written policies, only "the routine practice of failing to provide statutorily required services." ER00017 n.4. It then noted several purportedly statewide practices Plaintiffs had "identified" that "affect[ ]" the proposed Medicaid Subclass. ER00017. But the court did not even assert, let alone demonstrate, that any of these "practices" violate the Medicaid Act. Medicaid does not dictate limits on caseloads, set standards as to how complete service plans must be, create coordination criteria, specify the array of services the states must provide, or specify the number of therapeutic foster homes a state must enlist as alternatives to congregate care. *Cf.* ER00017-18.

Moreover, the evidence the district court cited never mentions the Named Plaintiffs; it is merely Plaintiffs' experts' generalized opinions of how the foster care system puts children "at risk." ER02556-70. The expert reports the district court relied upon never mentioned the Named Plaintiffs, and nothing links their general

opinions to B.T. or B.K. In short, neither the Plaintiffs nor the district court cited any evidence that Defendants ever "fail[ed] to provide" EPSDT services *to the Named Plaintiffs*. Nor did Plaintiffs even mention, let alone provide evidence of a violation of, Medicaid's "reasonable promptness" requirement as to the Named Plaintiffs. *See* 42 U.S.C. § 1396a(a)(8).

Defendant Betlach raised Plaintiffs' failure to prove a Medicaid violation below, but the district court dismissed it as a "merits" argument. ER00018. Although it was "not necessary to assess the merits of whether Defendants violated the Medicaid Act beyond the question of class certification," ER00018-19 n.5, it was necessary to analyze Plaintiffs' *evidence* to determine whether it established commonality and typicality. That is the only means by which Plaintiffs could establish they suffered a common injury from a violation of Medicaid law and that their claims are typical of the proposed Medicaid Subclass. *See Wal-Mart*, 564 U.S. at 350-51 (noting "sometimes it may be necessary for the court to probe behind the pleadings before coming to rest on the certification question," and that the requisite "'rigorous analysis' will entail some overlap with the merits of the plaintiff's underlying claim"). As Defendant Betlach's Petition for Permission to Appeal discussed, Plaintiffs provided no such evidence.

The district court added (in a footnote) the vague and unsupported finding that Plaintiffs had "offer[ed] evidence" that Defendants violated Named Plaintiffs' statutory rights by failing to:

> (1) detect and treat medical and dental needs, (2) provide annual well-child physicals, (3) provide semi-annual dental check-ups, and (4) provide timely immunizations. (Reply at 5-10.)

ER00018-19 n.5.

There was no such evidence. Neither the Reply cited by the district court nor the Reply's only reference to the two Named Plaintiffs provided any evidence that either Named Plaintiff had experienced a failure to detect or treat medical or dental needs or a failure to provide well-child physicals, semi-annual dental check-ups, or timely vaccinations as a result of Defendants' actions.

The evidence required by *Wal-Mart* was wholly lacking. If the two Named Plaintiffs could not demonstrate that either of them had suffered an injury from a Medicaid violation common to the putative Subclass, and that their claims are typical of the putative Subclass, certification contravened *Wal-Mart* and Rule 23(a). Therefore, in addition to the flaws discussed above, certification of the Medicaid Subclass should be reversed for lack of evidence to support standing, commonality, or typicality.

CONCLUSION

The district court's class certification order should be vacated and remanded with instructions to de-certify the General Class and Subclasses.

Dated: April 30, 2018

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STATEMENT OF RELATED CASES

There are no related cases pending in this Court.

Dated: April 30, 2018

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation of the Ninth Circuit Local Rules 32-1(a) and 32-2(b) and contains 15,304 words, exclusive of the portions exempted by Federal Rule of Appellate Procedure 32(f) as counted by the 2010 Microsoft Word word-processing program used to generate this brief, and is filed jointly by separately represented parties.

I certify that this brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using 2010 Microsoft Word word-processing program with a 14-point Garamond font.

Dated: April 30, 2018

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CERTIFICATE OF SERVICE

I certify that on April 30, 2018, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: April 30, 2018

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Nos. 17-17501 & 17-17502

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

B.K. by her next friend Margaret Tinsley, et al., Plaintiffs/Appellees, v. Gregory McKay, in his official capacity as Director of the Arizona Department of Child Safety, and Thomas J. Betlach, in his official capacity as Director of the Arizona Health Care Cost Containment System, Defendants/Appellants.	District Court No. 2:15-CV-00185-PHX-ROS

APPELLANTS' ADDENDUM TO JOINT OPENING BRIEF

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Chapter 83. Courts of Appeals (Refs & Annos)

28 U.S.C.A. § 1292

§ 1292. Interlocutory decisions

Currentness

(a) Except as provided in subsections (c) and (d) of this section, the courts of appeals shall have jurisdiction of appeals from:

(1) Interlocutory orders of the district courts of the United States, the United States District Court for the District of the Canal Zone, the District Court of Guam, and the District Court of the Virgin Islands, or of the judges thereof, granting, continuing, modifying, refusing or dissolving injunctions, or refusing to dissolve or modify injunctions, except where a direct review may be had in the Supreme Court;

(2) Interlocutory orders appointing receivers, or refusing orders to wind up receiverships or to take steps to accomplish the purposes thereof, such as directing sales or other disposals of property;

(3) Interlocutory decrees of such district courts or the judges thereof determining the rights and liabilities of the parties to admiralty cases in which appeals from final decrees are allowed.

(b) When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he shall so state in writing in such order. The Court of Appeals which would have jurisdiction of an appeal of such action may thereupon, in its discretion, permit an appeal to be taken from such order, if application is made to it within ten days after the entry of the order: *Provided, however*, That application for an appeal hereunder shall not stay proceedings in the district court unless the district judge or the Court of Appeals or a judge thereof shall so order.

(c) The United States Court of Appeals for the Federal Circuit shall have exclusive jurisdiction--

(1) of an appeal from an interlocutory order or decree described in subsection (a) or (b) of this section in any case over which the court would have jurisdiction of an appeal under section 1295 of this title; and

(2) of an appeal from a judgment in a civil action for patent infringement which would otherwise be appealable to the United States Court of Appeals for the Federal Circuit and is final except for an accounting.

(d)(1) When the chief judge of the Court of International Trade issues an order under the provisions of section 256(b) of this title, or when any judge of the Court of International Trade, in issuing any other interlocutory order, includes in the order a statement that a controlling question of law is involved with respect to which there is a substantial ground for difference of opinion and that an immediate appeal from that order may materially advance the ultimate termination of the litigation, the United States Court of Appeals for the Federal Circuit may, in its discretion, permit an appeal to be taken from such order, if application is made to that Court within ten days after the entry of such order.

(2) When the chief judge of the United States Court of Federal Claims issues an order under section 798(b) of this title, or when any judge of the United States Court of Federal Claims, in issuing an interlocutory order, includes in the order a statement that a controlling question of law is involved with respect to which there is a substantial ground for difference of opinion and that an immediate appeal from that order may materially advance the ultimate termination of the litigation, the United States Court of Appeals for the Federal Circuit may, in its discretion, permit an appeal to be taken from such order, if application is made to that Court within ten days after the entry of such order.

(3) Neither the application for nor the granting of an appeal under this subsection shall stay proceedings in the Court of International Trade or in the Court of Federal Claims, as the case may be, unless a stay is ordered by a judge of the Court of International Trade or of the Court of Federal Claims or by the United States Court of Appeals for the Federal Circuit or a judge of that court.

(4)(A) The United States Court of Appeals for the Federal Circuit shall have exclusive jurisdiction of an appeal from an interlocutory order of a district court of the United States, the District Court of Guam, the District Court of the Virgin Islands, or the District Court for the Northern Mariana Islands, granting or denying, in whole or in part, a motion to transfer an action to the United States Court of Federal Claims under section 1631 of this title.

(B) When a motion to transfer an action to the Court of Federal Claims is filed in a district court, no further proceedings shall be taken in the district court until 60 days after the court has ruled upon the motion. If an appeal is taken from the district court's grant or denial of the motion, proceedings shall be further stayed until the appeal has been decided by the Court of Appeals for the Federal Circuit. The stay of proceedings in the district court shall not bar the granting of preliminary or injunctive relief, where appropriate and where expedition is reasonably necessary. However, during the period in which proceedings are stayed as provided in this subparagraph, no transfer to the Court of Federal Claims pursuant to the motion shall be carried out.

(e) The Supreme Court may prescribe rules, in accordance with section 2072 of this title, to provide for an appeal of an interlocutory decision to the courts of appeals that is not otherwise provided for under subsection (a), (b), (c), or (d).

CREDIT(S)

(June 25, 1948, c. 646, 62 Stat. 929; Oct. 31, 1951, c. 655, § 49, 65 Stat. 726; Pub.L. 85-508, § 12(e), July 7, 1958, 72 Stat. 348; Pub.L. 85-919, Sept. 2, 1958, 72 Stat. 1770; Pub.L. 97-164, Title I, § 125, Apr. 2, 1982, 96 Stat. 36; Pub.L. 98-620, Title IV, § 412, Nov. 8, 1984, 98 Stat. 3362; Pub.L. 100-702, Title V, § 501, Nov. 19, 1988, 102 Stat. 4652; Pub.L. 102-572, Title I, § 101, Title IX, §§ 902(b), 906(c), Oct. 29, 1992, 106 Stat. 4506, 4516, 4518.)

Notes of Decisions (2881)

28 U.S.C.A. § 1292, 28 USCA § 1292
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

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United States Code Annotated
Title 28. Judiciary and Judicial Procedure (Refs & Annos)
Part IV. Jurisdiction and Venue (Refs & Annos)
Chapter 85. District Courts; Jurisdiction (Refs & Annos)

28 U.S.C.A. § 1331

§ 1331. Federal question

Currentness

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

CREDIT(S)

(June 25, 1948, c. 646, 62 Stat. 930; Pub.L. 85-554, § 1, July 25, 1958, 72 Stat. 415; Pub.L. 94-574, § 2, Oct. 21, 1976, 90 Stat. 2721; Pub.L. 96-486, § 2(a), Dec. 1, 1980, 94 Stat. 2369.)

Notes of Decisions (3080)

28 U.S.C.A. § 1331, 28 USCA § 1331
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

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United States Code Annotated
Title 28. Judiciary and Judicial Procedure (Refs & Annos)
Part IV. Jurisdiction and Venue (Refs & Annos)
Chapter 85. District Courts; Jurisdiction (Refs & Annos)

28 U.S.C.A. § 1343

§ 1343. Civil rights and elective franchise

Currentness

(a) The district courts shall have original jurisdiction of any civil action authorized by law to be commenced by any person:

(1) To recover damages for injury to his person or property, or because of the deprivation of any right or privilege of a citizen of the United States, by any act done in furtherance of any conspiracy mentioned in section 1985 of Title 42;

(2) To recover damages from any person who fails to prevent or to aid in preventing any wrongs mentioned in section 1985 of Title 42 which he had knowledge were about to occur and power to prevent;

(3) To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States;

(4) To recover damages or to secure equitable or other relief under any Act of Congress providing for the protection of civil rights, including the right to vote.

(b) For purposes of this section--

(1) the District of Columbia shall be considered to be a State; and

(2) any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

CREDIT(S)

(June 25, 1948, c. 646, 62 Stat. 932; Sept. 3, 1954, c. 1263, § 42, 68 Stat. 1241; Pub.L. 85-315, Part III, § 121, Sept. 9, 1957, 71 Stat. 637; Pub.L. 96-170, § 2, Dec. 29, 1979, 93 Stat. 1284.)

Notes of Decisions (1490)

28 U.S.C.A. § 1343, 28 USCA § 1343
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

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United States Code Annotated
Title 28. Judiciary and Judicial Procedure (Refs & Annos)
Part V. Procedure
Chapter 131. Rules of Courts

28 U.S.C.A. § 2072

§ 2072. Rules of procedure and evidence; power to prescribe

Currentness

(a) The Supreme Court shall have the power to prescribe general rules of practice and procedure and rules of evidence for cases in the United States district courts (including proceedings before magistrate judges thereof) and courts of appeals.

(b) Such rules shall not abridge, enlarge or modify any substantive right. All laws in conflict with such rules shall be of no further force or effect after such rules have taken effect.

(c) Such rules may define when a ruling of a district court is final for the purposes of appeal under section 1291 of this title.

CREDIT(S)

(Added Pub.L. 100-702, Title IV, § 401(a), Nov. 19, 1988, 102 Stat. 4648; amended Pub.L. 101-650, Title III, §§ 315, 321, Dec. 1, 1990, 104 Stat. 5115, 5117.)

FEDERAL COURT RULES

<The Federal Rules of Civil Procedure, together with the Notes of the Advisory Committee, Law Review Commentaries, and the judicial constructions of the Rules, are displayed at the end of this Title for convenient reference.>

Notes of Decisions (120)

28 U.S.C.A. § 2072, 28 USCA § 2072
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

End of Document

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedPrior Version Held Unconstitutional by Lewis v. Thompson, 2nd Cir.(N.Y.), May 22, 2001
KeyCite Yellow Flag - Negative TreatmentProposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XIX. Grants to States for Medical Assistance Programs (Refs & Annos)

42 U.S.C.A. § 1396a

§ 1396a. State plans for medical assistance

Currentness

(a)Contents

A State plan for medical assistance must--

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

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

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

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to

applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under chapter 21 of Title 41 to persons described in section 2102(a)(3) of Title 41;

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

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

(7) provide--

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

(i) the administration of the plan; and

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

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

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

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

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

(9) provide--

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

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

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17)[1] of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title, and

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

(10) provide--

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

(i) all individuals--

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37)[2], 606(h)[2], or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)[2] of this title),

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

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

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family;[3]

(V) who are qualified family members as defined in section 1396d(m)(1) of this title;[3]

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

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family;[4]

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

(IX) who--

(aa) are under 26 years of age;

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

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

(dd) were enrolled in the State plan under this subchapter or under a waiver of the plan while in such foster care;[6]

(ii) at the option of the State, to[7] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to[7] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

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

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

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

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;[3]

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

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

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;[3]

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

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

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

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;[3]

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);[3]

(X) who are described in subsection (m)(1) of this section;[3]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title;[3]

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals);[3]

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396***o*** of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);[3]

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title;[3]

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;[3]

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);[3]

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State;[3]

(XVIII) who are described in subsection (aa) of this section (relating to certain breast or cervical cancer patients);[4]

(XIX) who are disabled children described in subsection (cc)(1);[4]

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);[4]

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);[4] or

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

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

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

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

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

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

(ii) the plan must make available medical assistance--

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

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

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

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

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

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

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

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

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

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

(G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI of this chapter [42 U.S.C.A. § 1381 et seq.] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall

not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396*o*(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(o) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII of this chapter, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) of this section who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and section 1396*o*(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) of this section shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A) of this section, provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r-4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) of this section who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this section), (XIII) the medical assistance made available to an individual described in subsection (z)(1) of this section who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2) of this section), (XIV) the medical assistance made available to an individual described in subsection (aa) of this section who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer[8] (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1), (XVI)[9] the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting[10] and (XVII)[9] if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII);

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward

maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section[11] (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 [42 U.S.C.A. 1786];

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

(13) provide--

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

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

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

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

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

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

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

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

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

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

(17) except as provided in subsections (e)(14), (e)(15), (l)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,,[12] transfers of assets, and treatment of certain trusts;

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

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

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

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

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

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

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

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

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

(25) provide--

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

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

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

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

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

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

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

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

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

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

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

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

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

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

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

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

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

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

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

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

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

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

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

(28) provide--

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

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

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

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

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

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

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

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

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

services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

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

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

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

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

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

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

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so

pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

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

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide--

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

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

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

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

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

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

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

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

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

(41) provide, in accordance with subsection (kk)(8) (as applicable), that whenever a provider of services or any other

person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that--

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

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

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

(ii) provide assurances satisfactory to the Secretary that--

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

(II) from such amounts recovered, payment--

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

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

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

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

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

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

(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations,[13] the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and

(43) provide for--

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

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

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

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

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

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

(iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 1397hh(e) of this title[14], and

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

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

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

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

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

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

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

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

(ii) subsection (ee);

(47) provide--

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

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

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

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

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

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

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

(53) provide--

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

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

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

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

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV of this chapter and which include facilities defined as disproportionate share hospitals under section 1396r-4(a)(1)(A) of this title and Federally-qualified health centers described in section 1396d(1)(2)(B)[15]of this title, and

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

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

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

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

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

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

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary

that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

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

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

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

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

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

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

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

(66) provide for making eligibility determinations under section 1936u-5 of this title;

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

for the State where the PACE provider is located (in accordance with regulations issued by the Secretary);

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

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

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

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

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

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

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

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

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

(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are

licensed, qualified, competent, and courteous;

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

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

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

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

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

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

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

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

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

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

Secretary may require;

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

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

(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act; and

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

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

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

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

(81) provide for implementation of the payment models specified by the Secretary under section 1315a(c) of this title for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State;

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

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

(A) includes--

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

(I) the name of the physician or provider;

(II) the specialty of the physician or provider;

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

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

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

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

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

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

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

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

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

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

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

(b)Approval by Secretary

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

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

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

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

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

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

(d)Performance of medical or utilization review functions

If a State contracts with an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, or a utilization and quality control peer review organization[16] having a contract with the Secretary under part B of subchapter XI of this chapter for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

(e)Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan; individuals enrolled with health maintenance organizations; persons deemed recipients of supplemental security income or State supplemental payments; entitlement for certain newborns; postpartum eligibility for pregnant women

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

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

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

beginning on the date the individual's enrollment with the organization or entity becomes effective.

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

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

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

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

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

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

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

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

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

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

pregnancy) ends.

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

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

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

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

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

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1396b(a) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

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

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

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

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing

facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

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

(v) wishes to be cared for at home.

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

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

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV of this chapter pursuant to section 602(a)(43)[2] of this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV of this chapter and such aid is terminated pursuant to section 602(a)(43)[2] of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

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

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

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to

exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this subchapter under subsection (a)(10)(A) of this section shall remain eligible for those benefits until the earlier of--

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

(13)Express Lane option

(A)In general

(i)Option to use a finding from an Express Lane agency

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

(I)Prohibition on determining children ineligible for coverage

If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this subchapter and for child health assistance under subchapter XXI of this chapter, the State shall determine eligibility for assistance using its regular procedures.

(II)Notice requirement

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

(III)Compliance with screen and enroll requirement

The State shall satisfy the requirements under subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll) before enrolling a child in child health assistance under subchapter XXI of this chapter. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

(IV)Verification of citizenship or Nationality status

The State shall satisfy the requirements of subsection (a)(46)(B) of this section or 1397ee(c)(9) of this title, as applicable for verifications of citizenship or nationality status.

(V)Coding

The State meets the requirements of subparagraph (E).

(ii)Option to apply to renewals and redeterminations

The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

(B)Rules of construction

Nothing in this paragraph shall be construed--

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

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

(C)Options for satisfying the screen and enroll requirement

(i)In general

With respect to a child whose eligibility for medical assistance under this subchapter or for child health assistance

under subchapter XXI of this chapter has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii)Establishing a screening threshold

(I)In general

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

(II)Children with income not above threshold

If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this subchapter regardless of whether such child would otherwise satisfy such criteria.

(III)Children with income above threshold

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

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

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

(iii)Temporary enrollment in CHIP pending screen and enroll

(I)In general

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

(II)Determination of eligibility

During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under subchapter XXI of this chapter or for medical assistance under this subchapter in accordance with this clause.

(III)Prompt follow up

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

(IV)Requirement for simplified determination

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

(V)Availability of CHIP matching funds during temporary enrollment period

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

(D)Option for automatic enrollment

(i)In general

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

(ii)Information requirement

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

(E)Coding; application to enrollment error rates

(i)In general

For purposes of subparagraph (A)(iv)[17]the requirement of this subparagraph for a State is that the State agrees to--

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

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

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

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

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

(ii)No punitive action based on error rate

The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii)Rule of construction

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

(iv)Error rate defined

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

(F)Express Lane agency

(i)In general

In this paragraph, the term "Express Lane agency" means a public agency that--

(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making

the determinations of one or more eligibility requirements described in subparagraph (A)(i);

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

(III) notifies the child's family--

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

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

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

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

(ii)Inclusion of specific public agencies and Indian tribes and tribal organizations

Such term includes the following:

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

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

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

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

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

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

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

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

(ii) The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.).

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

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

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

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

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

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

(iii)Exclusions

Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under subchapter XX of this chapter or a private, for-profit organization.

(iv)Rules of construction

Nothing in this paragraph shall be construed as--

(I) exempting a State Medicaid agency from complying with the requirements of subsection (a)(4) of this section relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest);[18] or

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

(v)Additional definitions

In this paragraph:

(I)State

The term “State” means 1 of the 50 States or the District of Columbia.

(II)State CHIP agency

The term “State CHIP agency” means the State agency responsible for administering the State CHIP plan.

(III)State CHIP plan

The term “State CHIP plan” means the State child health plan established under subchapter XXI of this chapter and includes any waiver of such plan.

(IV)State Medicaid agency

The term “State Medicaid agency” means the State agency responsible for administering the State Medicaid plan.

(V)State Medicaid plan

The term "State Medicaid plan" means the State plan established under subchapter XIX of this chapter and includes any waiver of such plan.

(G)Child defined

For purposes of this paragraph, the term "child" means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

(H)State option to rely on State income tax data or return

At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

(I)Application

This paragraph shall not apply with respect to eligibility determinations made after September 30, 2027.

(14)Income determined using modified adjusted gross income

(A)In general

Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on March 23, 2010. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B)No income or expense disregards

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

(C)No assets test

A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D)Exceptions

(i)Individuals eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals eligible for medicare cost-sharing

Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

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

(II) Individuals who have attained age 65.

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

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

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

(ii)Express Lane agency findings

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

(iii)Medicare prescription drug subsidies determinations

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

(iv)Long-term care

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

(v)Grandfather of current enrollees until date of next regular redetermination

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

(E)Transition planning and oversight

Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on March 23, 2010. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, no longer being eligible for such assistance.

(F)Limitation on secretarial authority

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

(G)Definitions of modified adjusted gross income and household income

In this paragraph, the terms “modified adjusted gross income” and “household income” have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H)Continued application of Medicaid rules regarding point-in-time income and sources of income

The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of--

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

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

(I)Treatment of portion of modified adjusted gross income

For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall--

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

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

(J)Exclusion of parent mentor compensation from income determination

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

(K)Treatment of certain lottery winnings and income received as a lump sum

(i)In general

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

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

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

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

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

(ii)Counting in equal installments

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

(iii)Hardship exemption

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

(iv)Notifications and assistance required in case of loss of eligibility

A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)--

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

(aa) of the individual's opportunity to enroll in a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

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

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

(v)Qualified lottery winnings defined

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

(vi)Qualified lump sum income defined

In this subparagraph, the term "qualified lump sum income" means income that is received as a lump sum from monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section

1955(b)(4) of Title 18).

(15)Exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition

The first $2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1382a(b)(26) of this title shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

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

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section and section 1382h(b)(3) of this title and section 1396r-5 of this title, except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

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

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

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

Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care.

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

(1) In addition to any other authority under State law, where a State determines that a[19] intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies--

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

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

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

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

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

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(f) of this title, or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of section 1396d(a) of this title.

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

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

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

(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2),[20] the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1396u-1 of this title.

(l)Description of group

(1) Individuals described in this paragraph are--

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

(B) infants under one year of age,

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

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

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

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

account.

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

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) of this section and for children described in subsection (a)(10)(A)(i)(VI) of this section or subsection (a)(10)(A)(i)(VII) of this section in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

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

(m)Description of individuals

(1) Individuals described in this paragraph are individuals--

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1382c(a)(3) of this title),

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

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

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) of this section and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level

described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A) of this section.

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

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

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

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

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

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

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

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

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

(n)Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this subchapter throughout a month, and

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

(2) The minimum monthly personal needs allowance described in this paragraph[21] is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In order to meet the requirements of subsection (a)(55)[22]of this section, the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1396r-4(b)(1) of this title, shall--

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

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

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

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

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

(u)Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals--

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

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved,

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

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

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

(3) In this subsection, the term "COBRA continuation coverage" means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [42 U.S.C.A. § 300bb-1 et seq.] section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1161 et seq.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(x)Physician identifier system; establishment

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

(y)Intermediate sanctions for psychiatric hospitals

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

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

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

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

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

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

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be

out of compliance with such requirements, if--

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

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

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

(z)Optional coverage of TB-related services

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

(A) who are infected with tuberculosis;

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

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

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

(A) Prescribed drugs.

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

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

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

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

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

(aa)Certain breast or cervical cancer patients

Individuals described in this subsection are individuals who

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

(2) have not attained age 65;

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

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

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

(1)In general

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

(2)Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395*l*(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395*l*(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3)Fiscal year 2002 and succeeding fiscal years

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

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

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

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

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

(5)Administration in the case of managed care

(A)In general

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

(B)Payment schedule

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

(6)Alternative payment methodologies

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

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

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

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

(1) Individuals described in this paragraph are individuals--

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

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

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

fiscal year 2008; and

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

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

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

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

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

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

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

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

(i) notwithstanding section 1396e of this title, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) of this section if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

(ii) if such coverage is obtained--

(I) subject to paragraph (2) of section 1396*o*(h)[23] of this title, reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on

behalf of a child with a disability; and

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

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

(dd)Electronic transmission of information

If the State agency determining eligibility for medical assistance under this subchapter or child health assistance under subchapter XXI of this chapter verifies an element of eligibility based on information from an Express Lane Agency[24] (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1320b-7(d)(2) of this title may be met through evidence in digital or electronic form.

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

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

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

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

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

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

(I) notifies the individual of such fact;

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

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

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

(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of social security--

(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information submitted under subparagraph (A) for an individual enrolled in the State plan under this subchapter who declares to be[25] citizen or national on at least a monthly basis; or

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

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1396b(x)(3) of this title) as is provided under clauses (i) and (ii) of section 1320b-7(d)(4)(A) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

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

(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

(ii) the inconsistency is not resolved by the State;

(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

(iv) payment has been made for an item or service furnished to the individual under this subchapter.

(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent--

(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this subchapter and to identify and implement changes in such procedures to improve their accuracy; and

(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

(4) Nothing in this subsection shall affect the rights of any individual under this subchapter to appeal any disenrollment from

a State plan.

(ff)Disregard of certain property in determination of eligibility of Indians

Notwithstanding any other requirement of this subchapter or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this subchapter:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act [43 U.S.C.A. 1601 et seq.], and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(gg)Maintenance of effort

(1)General requirement to maintain eligibility standards until State exchange is fully operational

Subject to the succeeding paragraphs of this subsection, during the period that begins on March 23, 2010 and ends on the date on which the Secretary determines that an Exchange established by the State under section 18031 of this title is fully operational, as a condition for receiving any Federal payments under section 1396b(a) of this title for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on March 23, 2010.

(2)Continuation of eligibility standards for children through September 30, 2027

The requirement under paragraph (1) shall continue to apply to a State through September 30, 2027 (but during the period that begins on October 1, 2019, and ends on September 30, 2027, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved) with respect to the eligibility standards, methodologies, and procedures under the State plan under this subchapter or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

(3)Nonapplication

During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4)Determination of compliance

(A)States shall apply modified adjusted gross income

A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010 for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(B)States may expand eligibility or move waivered populations into coverage under the State plan

With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on March 23, 2010, or that makes individuals who, on March 23, 2010, are eligible for medical assistance under a waiver of the State plan, after March 23, 2010 eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010 for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(hh)State option for coverage for individuals with income that exceeds 133 percent of the poverty line

(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

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

(ii)State eligibility option for family planning services

(1) Individuals described in this subsection are individuals--

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this subchapter (or under its State child health plan under subchapter XXI of this chapter) for pregnant women; and

(B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause[26] (XVI) of the matter following subparagraph (G) of section[27] subsection (a)(10) pursuant to a waiver granted under section 1315 of this title.

(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.

(jj)Primary care services defined

For purposes of subsection (a)(13)(C), the term "primary care services" means--

(1) evaluation and management services that are procedure codes (for services covered under subchapter XVIII of this chapter) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1395w-4(c)(5) of this title as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.

(kk)Provider and supplier screening, oversight, and reporting requirements

For purposes of subsection (a)(77), the requirements of this subsection are the following:

(1)Screening

The State complies with the process for screening providers and suppliers under this subchapter, as established by the Secretary under section 1395cc(j)(2) of this title.

(2)Provisional period of enhanced oversight for new providers and suppliers

The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this subchapter, as established by the Secretary under section 1395cc(j)(3) of this title.

(3)Disclosure requirements

The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1395cc(j)(5) of this title.

(4)Temporary moratorium on enrollment of new providers or suppliers

(A)Temporary moratorium imposed by the Secretary

(i)In general

Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1395cc(j)(7) of this title.

(ii)Exceptions

(I)Compliance with moratorium

A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

(II)FFP available

Notwithstanding section 1396b(i)(2)(E) of this title, payment may be made to a State under this subchapter with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this subchapter (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.

(iii)Limitation on charges to beneficiaries

With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1395cc(j)(7) of this title from charging an individual or other person eligible to receive medical assistance under the State plan under this subchapter (or a waiver of the plan) for an item or service described in section 1396b(i)(2)(E) of this title furnished to such an individual.

(B)Moratorium on enrollment of providers and suppliers

At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

(5)Compliance programs

The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1395cc(j)(7) of this title, a compliance program that contains the core elements

established under subparagraph (B) of that section 1395cc(j)(7) of this title for providers or suppliers within a particular industry or category.

(6)Reporting of adverse provider actions

The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

(7)Enrollment and NPI of ordering or referring providers

The State requires--

(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

(8)Provider terminations

(A)In general

Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 30 days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate--

(i) the name of such provider or person;

(ii) the provider type of such provider or person;

(iii) the specialty of such provider's or person's practice;

(iv) the date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);

(v) the reason for the termination;

(vi) a copy of the notice of termination sent to the provider or person;

(vii) the date on which such termination is effective, as specified in the notice; and

(viii) any other information required by the Secretary.

(B)Effective date defined

For purposes of this paragraph, the term "effective date" means, with respect to a termination described in subparagraph (A), the later of--

(i) the date on which such termination is effective, as specified in the notice of such termination; or

(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.

(9)Other State oversight

Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

(ll)Termination notification database

In the case of a provider of services or any other person whose participation under this subchapter or subchapter XXI of this chapter is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111-148).

(mm)Directory physician or provider described

A physician or provider described in this subsection is--

(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that--

(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

(B) received payment under the State plan in the 12-month period preceding such date; and

(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XIX, § 1902, as added Pub.L. 89-97, Title I, § 121(a), July 30, 1965, 79 Stat. 344; amended Pub.L. 90-248, Title II, §§ 210(a)(6), 223(a), 224(a), (c)(1), 227(a), 228(a), 229(a), 231, 234(a), 235(a), 236(a), 237, 238, 241(f)(1) to (4), Title III, § 302(b), Jan. 2, 1968, 81 Stat. 896, 901 to 906, 908, 911, 917, 929; Pub.L. 91-56, § 2(c), (d), Aug. 9, 1969, 83 Stat. 99; Pub.L. 92-223, § 4(b), Dec. 28, 1971, 85 Stat. 809; Pub.L. 92-603, Title II, §§ 208(a), 209(a), (b)(1), 221(c)(5), 231, 232(a), 236(b), 237(a)(2), 239(a), (b), 240, 246(a), 249(a), 255(a), 268(a), 274(a), 278(a)(18) to (20), (b)(14), 298, 299A, 299D(b), Oct. 30, 1972, 86 Stat. 1381, 1389, 1410, 1415 to 1418, 1424, 1426, 1446, 1450, 1452 to 1454, 1460, 1462; Pub.L. 93-233, §§ 13(a)(2) to (10), 18(o) to (q), (x)(1) to (4), Dec. 31, 1973, 87 Stat. 960 to 962, 971, 972; Pub.L. 93-368, § 9(a), Aug. 7, 1974, 88 Stat. 422; Pub.L. 94-48, §§ 1, 2, July 1, 1975, 89 Stat. 247; Pub.L. 94-182, Title I, § 111(a), Dec. 31, 1975, 89 Stat. 1054; Pub.L. 94-552, § 1, Oct. 18, 1976, 90 Stat. 2540; Pub.L. 95-142, §§ 2(a)(3), (b)(1), 3(c)(1), 7(b), (c), 9, 19(b)(2), 20(b), Oct. 25, 1977, 91 Stat. 1176, 1178, 1193, 1195, 1204, 1207; Pub.L. 95-210, § 2(c), Dec. 13, 1977, 91 Stat. 1488; Pub.L. 95-559, § 14(a)(1), Nov. 1, 1978, 92 Stat. 2140; Pub.L. 96-272, Title III, § 308(c), June 17, 1980, 94 Stat. 531; Pub.L. 96-499, Title IX, §§ 902(b), 903(b), 905(a), 912(b), 913(c), (d), 914(b)(1), 916(b)(1), 918(b)(1), 962(a), 965(b), Dec. 5, 1980, 94 Stat. 2613, 2615, 2618 to 2621, 2624, 2626, 2650, 2652; Pub.L. 96-611, § 5(b), Dec. 28, 1980, 94 Stat. 3568; Pub.L. 97-35, Title XXI, §§ 2105(c), 2113(m), 2171(a), (b), 2172(a), 2173(a), (b)(1), (d), 2174(a), 2175(a), (d)(1), 2178(b), 2181(a)(2), 2182, 2193(c)(9), Aug. 13, 1981, 95 Stat. 792, 795, 807 to 809, 811, 814 to 816, 828; Pub.L. 97-248, Title I, §§ 131(a), (c) [formerly (b)], 132(a), (c), 134(a), 136(d), 137(a)(3), (b)(7) to (10), (e), 146(a), Sept. 3, 1982, 96 Stat. 367, 369, 370, 373, 375 to 378, 381, 394; Pub.L. 97-448, Title III, § 309(a)(8), Jan. 12, 1983, 96 Stat. 2408; Pub.L. 98-369, Div. B, Title III, §§ 2303(g)(1), 2314(b), 2335(e), 2361(a), 2362(a), 2363(a)(1), 2367(a), 2368(a), (b), 2373(b)(1) to (10), Title VI, §§ 2651(c), July 18, 1984, 98 Stat. 1066, 1079, 1091, 1104, 1105, 1108, 1109, 1111, 1149; Pub.L. 98-378, § 20(c), Aug. 16, 1984, 98 Stat. 1322; Pub.L. 98-617, § 3(a)(7), (b)(10), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub.L. 99-272, Title IX,

§§ 9501(b), (c), 9503(a), 9505(b), (c)(1), (d), 9506(a), 9509(a), 9510(a), 9517(b), 9529(a)(1), (b)(1), Title XII, § 12305(b)(3), Apr. 7, 1986, 100 Stat. 201, 202, 205, 208 to 212, 216, 220, 293; Pub.L. 99-509, Title IX, §§ 9320(h)(3), 9401(a) to (e)(1), 9402(a)(1), (2)(b), 9403(a), (c), (e), (f)(1), (2), (g)(1), (4)(A), 9404(a), 9405, 9406(b), 9407(a), 9408(a), (b), (c)(2), (3), 9431(a), (b)(1), 9433(a), 9435(b)(1), Oct. 21, 1986, 100 Stat. 2016, 2050 to 2058, 2060, 2061, 2066, 2068, 2069; Pub.L. 99-514, Title XVIII, § 1895(c)(1), (3)(B), (C), (7), Oct. 22, 1986, 100 Stat. 2935, 2936; Pub.L. 99-570, Title XI, § 11005(b), Oct. 27, 1986, 100 Stat. 3207-169; Pub.L. 99-643, §§ 3(b), 7(b), Nov. 10, 1986, 100 Stat. 3575, 3579; Pub.L. 100-93, §§ 5(a), 7, 8(f), Aug. 18, 1987, 101 Stat. 689, 691, 694; Pub.L. 100-203, Title IV, §§ 4072(d), 4101(a)(1), (2), (b)(1) to (2)(B), (c)(2), (e)(1) to (5), 4102(b)(1), 4104, 4113(a)(2), (b)(1), (2), (c)(1), (2), (d)(2), 4116, 4118(c)(1), (h)(1), (2), (m)(1)(B), (p)(1) to (4), (6) to (8), 4211(b)(1), (h)(1) to (5), 4212(d)(2), (3), (e)(1), 4213(b)(1), 4218(a), Title IX, §§ 9115(b), 9119(d)(1), Dec. 22, 1987, 101 Stat. 1330-117, 1330-140 to 1330-143, 1330-146, 1330-147, 1330-151, 1330-152, 1330-154 to 1330-157, 1330-159, 1330-203, 1330-205, 1330-213, 1330-219, 1330-220, 1330-305; Pub.L. 100-360, Title II, § 204(d)(3), Title III, §§ 301(a)(1), (e)(2), 302(a), (b)(1), (c)(1), (2), (d) to (e)(3), 303(d), (e), Title IV, § 411(k)(5)(A), (B), (7)(B) to (D), (10)(G)(ii), (iv), (17)(B), (l)(3)(E), (H), (J), (6)(C), (D), (8)(C), (n)(2), (4) [formerly (3)], July 1, 1988, 102 Stat. 729, 748 to 753, 762, 763, 791, 792, 794, 796, 800, 803, 804, 805, 807; Pub.L. 100-485, Title II, § 202(c)(4), Title III, § 303(a)(2), (b)(1), (d), Title IV, § 401(d)(1), Title VI, § 608(d)(14)(I), (15)(A), (B), (16)(C), (27)(F) to (H), (28), Oct. 13, 1988, 102 Stat. 2378, 2391, 2392, 2396, 2416, 2418, 2423; Pub.L. 100-647, Title VIII, § 8434(b)(1), (2), Nov. 10, 1988, 102 Stat. 3805; Pub.L. 101-234, Title II, § 201(a)(1), Dec. 13, 1989, 103 Stat. 1981; Pub.L. 101-239, Title VI, §§ 6115(c), 6401(a), 6402(a), (c)(2), 6403(b), (d)(1), 6404(c), 6405(b), 6406(a), 6408(c)(1), (d)(1), (4)(C), 6411(a)(1), (d)(3)(B), (e)(2), Dec. 19, 1989, 103 Stat. 2219, 2258 to 2261, 2263 to 2266, 2268 to 2271; Pub.L. 101-508, Title IV, §§ 4401(a)(2), 4402(a)(1), (c), (d)(1), 4501(b), (e)(2), 4601(a)(1), 4602(a), 4603(a), 4604(a), (b), 4701(b)(1), 4704(a), (e)(1), 4708(a), 4711(c)(1), (d), 4713(a), 4715(a), 4723(b), 4724(a), 4732(b)(1), 4751(a), 4752(a)(1)(A), (c)(1), 4754(a), 4755(a)(2), (c)(1), 4801(e)(1)(A), (11)(A), Nov. 5, 1990, 104 Stat. 1388-143, 1388-161, 1388-163 to 1388-173, 1388-186, 1388-187, 1388-190, 1388-192, 1388-194, 1388-195, 1388-204, 1388-206, 1388-208 to 1388-210, 1388-215, 1388-217; Pub.L. 102-234, §§ 2(b)(1), 3(a), Dec. 12, 1991, 105 Stat. 1799; Pub.L. 103-66, Title XIII, §§ 13581(b)(2), 13601(b), 13602(c), 13603(a) to (c), 13611(d)(1), 13622(a)(1), (b), (c), 13623(a), 13625(a), 13631(a), (e)(1), (f)(1), Aug. 10, 1993, 107 Stat. 611, 613, 619, 626, 632, 633, 636, 643, 644; Pub.L. 103-296, Title I, § 108(d)(1), Aug. 15, 1994, 108 Stat. 1486; Pub.L. 103-448, Title II, § 204(w)(2)(E), Nov. 2, 1994, 108 Stat. 4746; Pub.L. 104-193, Title I, §§ 108(k), 114(b), (c), (d)(1), Title IX, § 913, Aug. 22, 1996, 110 Stat. 2169, 2180, 2354; Pub.L. 104-226, § 1(b)(2), Oct. 2, 1996, 110 Stat. 3033; Pub.L. 104-248, § 1(a)(1), Oct. 9, 1996, 110 Stat. 3148; Pub.L. 105-12, § 9(b)(2), Apr. 30, 1997, 111 Stat. 26; Pub.L. 105-33, Title IV, §§ 4106(c), 4454(b)(1), 4701(b)(2)(A)(i) to (iv), (d)(1), 4702(b)(2), 4709, 4711(a), 4712(a), (b)(1), (c)(1), 4714(a)(1), 4715(a), 4724(c)(1), (d), (f), (g)(1), 4731(a), (b), 4732(a), 4733, 4741(a), 4751(a), (b), 4752(a), 4753(b), 4911(b), 4912(b)(1), 4913(a), Aug. 5, 1997, 111 Stat. 368, 431, 493, 495, 506, 507, 508, 509, 510, 516, 517, 519, 520, 522, 523, 524, 525, 571, 573; Pub.L. 106-113, Div. 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3101(a), 3102, Feb. 22, 2012, 126 Stat. 191; Pub.L. 112-240, Title VI, §§ 621(a), 622, 623, 642(b)(2), Jan. 2, 2013, 126 Stat. 2352, 2358; Pub.L. 113-67, Div. A, Title II, § 202(b)(1), Div. B, Title II, §§ 1201(a), 1202, Dec. 26, 2013, 127 Stat. 1177, 1198, 1199, as amended Pub.L. 115-123, Div. E, Title XII, § 53102(b)(1), Feb. 9, 2018, 132 Stat. 298; Pub.L. 113-93, Title II, §§ 201(a), 202, 203, Apr. 1, 2014, 128 Stat. 1045, 1046; Pub.L. 114-10, Title II, §§ 211(a), 212(b), Title III, § 302, Apr. 16, 2015, 129 Stat. 151, 152, 158; Pub.L. 114-63, § 2, Oct. 7, 2015, 129 Stat. 549; Pub.L. 114-198, Title VII, § 706(b)(1), July 22, 2016, 130 Stat. 754; Pub.L. 114-255, Div. A, Title V, §§ 5005(a)(1), (3), (6), (b)(1), (c)(2), 5006(a), (b), Div. C, Title XVII, § 17004(b)(1)(B), (C), (2)(B), Dec. 13, 2016, 130 Stat. 1191, 1192, 1193, 1195, 1196, 1332, 1333; Pub.L. 115-120, Div. C, §§ 3002(e), (f)(2), 3004(c), Jan. 22, 2018, 132 Stat. 34, 35, 37; Pub.L. 115-123, Div. E, Title I, §§ 50101(e), (f)(2), Title XII, §§ 53102(a)(1), (d)(2), 53103(a), Feb. 9, 2018, 132 Stat. 174, 175, 298, 299, 300.)

AMENDMENT OF SUBSEC. (A)(25)(E)(I)

<Pub.L. 113-67, Div. A, Title II, § 202(a)(1), (c), Dec. 26, 2013, 127 Stat. 1177, as amended, provided that, effective on October 1, 2019, subpar. (E)(i) of subsec. (a)(25) is amended by inserting before the semicolon at the end: ", except that the State may, if the state determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services".>

AMENDMENT OF SUBSEC. (A)(25)(F)(I)

<Pub.L. 113-67, Div. A, Title II, § 202(a)(2), (c), Dec. 26, 2013, 127 Stat. 1177, as amended, provided that, effective on October 1, 2019, subpar. (F)(i) of subsec. (a)(25) is amended by striking "30 days after such services are furnished" and inserting "90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.">

REPEAL OF SUBSEC. (A)(29)

<Pub.L. 101-508, Title IV, § 4801(e)(11), (11)(A), Nov. 5, 1990, 104 Stat. 1388-217, repealed subsec. (a)(29) of this section effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title.>

Notes of Decisions (1407)

Footnotes

1 See Codifications note set out under this section.

2 Sections 602 and 606 of this title, were repealed and new sections 602 and 606 enacted by Pub.L. 104-193, Title I, § 103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and as enacted section 602 no longer contains subsec. (a)(37) or (a)(43), and section 606 no longer contains subsec. (h). Section 682 of this title, was repealed by Pub.L. 104-193, Title I, § 108(e), Aug. 22, 1996, 110 Stat. 2167.

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

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

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

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

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

8 So in original. A comma probably should appear.

9 So in original. Two subclauses XVI have been enacted.

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

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

12 So in original.

13 So in original. Probably should be “Investigation,”.

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

15 So in original. Probably should be section “1396d(l)(2)(B)”.

16 So in original. Probably should be “a quality improvement organization”.

17 So in original. Probably should be “subparagraph (A)(i)(V),”.

18 So in original. The closing parenthesis probably should not appear.

19 So in original. Probably should be “an”.

20 So in original. Another closing parenthesis probably should precede the comma.

21 So in original. The words “this paragraph” probably should be “this subsection”.

22 So in original. Probably should be subsection “(a)(56)”.

23 So in original. Probably should be “section 1396***o***(i)”.

[24] So in original. Probably should be “agency”.

[25] So in original. Probably should be followed by “a”.

[26] So in original. Probably should be “subclause”.

[27] So in original. The word “section” probably should not appear.

42 U.S.C.A. § 1396a, 42 USCA § 1396a
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

End of Document

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedNegative Treatment Reconsidered by Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services, 11th Cir.(Fla.), Aug. 12, 2011

KeyCite Yellow Flag - Negative TreatmentProposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XIX. Grants to States for Medical Assistance Programs (Refs & Annos)

42 U.S.C.A. § 1396d

§ 1396d. Definitions

Effective: December 13, 2016

Currentness

For purposes of this subchapter--

(a) Medical assistance

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

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

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

(iii) 65 years of age or older,

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

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

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

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

(viii) pregnant women,

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

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

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

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

(xiii) individuals described in section 1396a(aa)[1] of this title,

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

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

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

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

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

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

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

(3) other laboratory and X-ray services;

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

(5) (A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

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

(7) home health care services;

(8) private duty nursing services;

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

(10) dental services;

(11) physical therapy and related services;

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

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

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

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

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

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

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

(16) (A) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section, and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph;

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

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

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

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

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

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

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

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

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

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

(27) subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for

individuals who have Sickle Cell Disease;

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

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

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

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

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

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

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

Subject to subsections (y), (z), and (aa) and section 1396u-3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible

for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title, and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D). The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r-4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

(c) Nursing facility

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

(d) Intermediate care facility for mentally retarded

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

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

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

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

(e) Physicians' services

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

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

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

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

(f) Nursing facility services

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

(g) Chiropractors' services

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

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

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

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

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

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as

defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

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

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

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

(i) Institution for mental diseases

The term “institution for mental diseases” means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) State supplementary payment

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

(k) Supplemental security income benefits

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

(l) Rural health clinics

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

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

(B) The term "Federally-qualified health center" means an entity which--

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

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

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

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

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

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

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

(B) The term "freestanding birth center" means a health facility--

(i) that is not a hospital;

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

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

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

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

(m) Qualified family member

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

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

(n) "Qualified pregnant woman or child" defined

The term "qualified pregnant woman or child" means--

(1) a pregnant woman who--

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

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

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

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

(o) Optional hospice benefits

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

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

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

(2) An individual's voluntary election under this subsection--

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

(B) shall be for such a period or periods (which need not be the same periods described in section 1395d(d)(1) of this title) as the State may establish; and

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

(3) In the case of an individual--

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

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

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

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

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual--

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

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

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

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

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

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

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

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

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

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

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

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

(ii) premiums under section 1395r of this title,[4]

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

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

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

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

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

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

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B)[5] or[6] 1396a(a)(10)(E)(iii) of this title of such paragraph[5] any percent.

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

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

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

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

(q) Qualified severely impaired individual

The term "qualified severely impaired individual" means an individual under age 65--

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

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

payment under section 1382e(c)(3) of this title, and

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

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

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

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

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

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

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

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

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

(1) Screening services--

(A) which are provided--

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

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

(B) which shall at a minimum include--

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

(ii) a comprehensive unclothed physical exam,

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

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

(v) health education (including anticipatory guidance).

(2) Vision services--

(A) which are provided--

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

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

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

(3) Dental services--

(A) which are provided--

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

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

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

(4) Hearing services--

(A) which are provided--

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

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

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

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

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as

preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(s) Qualified disabled and working individual

The term "qualified disabled and working individual" means an individual--

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

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

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

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

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

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

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

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

(B) At State option--

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

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

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

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

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

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

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

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

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

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

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

pediatrician.

(u) Conditions for State plans

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

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

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

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

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

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

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

(v) Employed individual with a medically improved disability

(1) The term "employed individual with a medically improved disability" means an individual who

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

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

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

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

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

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

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

(w) Independent foster care adolescent

(1) For purposes of this subchapter, the term "independent foster care adolescent" means an individual--

(A) who is under 21 years of age;

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

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

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

(3) A State may limit the eligibility of independent foster care adolescents under section 1396a(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter [42 U.S.C.A. § 670 et seq.] before the date the individuals attained 18 years of age.

(x) Strategies, treatment, and services

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

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

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

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

(y) Increased FMAP for medical assistance for newly eligible mandatory individuals

(1) Amount of increase

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

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

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

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

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

(2) Definitions

In this subsection:

(A) Newly eligible

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

(B) Full benefits

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

(z) Equitable support for certain States

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title.

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

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

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

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.[7]

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

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

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

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

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

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent;

(IV) 2017 is 80 percent;

(V) 2018 is 90 percent; and

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

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

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

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

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

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, State's regular FMAP for such fiscal year shall be increased by 25 percent (or 50 percent in the case of fiscal year 2013) of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.

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

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) In this subsection, the term "regular FMAP" means, for each fiscal year for which this subsection applies to a State, the Federal medical assistance percentage that would otherwise apply to the State for the fiscal year, as determined under subsection (b) and without regard to this subsection, subsections (y) and (z), and section 10202 of the Patient Protection and Affordable Care Act.

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

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

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

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

(B) by any other health care professional who--

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

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

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

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

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

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

(cc) Requirement for certain States

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

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

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

CREDIT(S)

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

Stat. 2651; Pub.L. 97-35, Title XXI, §§ 2162(a)(2), 2172(b), Aug. 13, 1981, 95 Stat. 806, 808; Pub.L. 97-248, Title I, §§ 136(c), 137(b)(17), (18), (f), Sept. 3, 1982, 96 Stat. 376, 379, 381; Pub.L. 98-369, Div. B, Title III, §§ 2335(f), 2340(b), 2361(b), 2371(a), 2373(b)(15) to (20), July 18, 1984, 98 Stat. 1091, 1093, 1104, 1110, 1112; Pub.L. 99-272, Title IX, §§ 9501(a), 9505(a), 9511(a), Apr. 7, 1986, 100 Stat. 201, 208, 212; Pub.L. 99-509, Title IX, §§ 9403(b), (d), (g)(3), 9404(b), 9408(c)(1), 9435(b)(2), Oct. 21, 1986, 100 Stat. 2053, 2054, 2056, 2061, 2070; Pub.L. 99-514, Title XVIII, § 1895(c)(3)(A), Oct. 22, 1986, 100 Stat. 2935; Pub.L. 100-203, Title IV, §§ 4073(d), 4101(c)(1), 4103(a), 4105(a), 4114, 4118(p)(8), 4211(e), (f), (h)(6), Dec. 22, 1987, 101 Stat. 1330-119, 1330-141, 1330-146, 1330-147, 1330-152, 1330-159, 1330-204 to 1330-206; Pub.L. 100-360, Title III, § 301(a)(2) to (d), (g)(2), Title IV, § 411(h)(4)(E), (k)(4), (8)(A), (B), (14)(A), July 1, 1988, 102 Stat. 748, 750, 791, 794, 798; Pub.L. 100-485, Title III, § 303(b)(2), Title IV, § 401(d)(2), Title VI, § 608(d)(14)(A) to (G), (J), (f)(3), Oct. 13, 1988, 102 Stat. 2392, 2396, 2415, 2416, 2424; Pub.L. 100-647, Title VIII, § 8434(a), (b)(3), (4), Nov. 10, 1988, 102 Stat. 3805; Pub.L. 101-234, Title II, § 201(b), Dec. 13, 1989, 103 Stat. 1981; Pub.L. 101-239, Title VI, §§ 6402(c)(1), 6403(a), (c), (d)(2), 6404(a), (b), 6405(a), 6408(d)(2), (4)(A), (B), Dec. 19, 1989, 103 Stat. 2261 to 2265, 2268, 2269; Pub.L. 101-508, Title IV, §§ 4402(d)(2), 4501(a), (c), (e)(1), 4601(a)(2), 4704(c), (d), (e)(1), 4705(a), 4711(a), 4712(a), 4713(b), 4717, 4719(a), 4721(a), 4722, 4755(a)(1)(A), Nov. 5, 1990, 104 Stat. 1388-163 to 1388-166, 1388-172, 1388-174, 1388-187, 1388-191, 1388-193, 1388-194, 1388-209; Pub.L. 103-66, Title XIII, §§ 13601(a), 13603(e), 13605(a), 13606(a), 13631(f)(2), (g)(1), Aug. 10, 1993, 107 Stat. 612, 613, 620, 621, 644, 645; Pub.L. 103-296, Title I, § 108(d)(2), (3), Aug. 15, 1994, 108 Stat. 1486; Pub.L. 104-299, § 4(b)(2), Oct. 11, 1996, 110 Stat. 3645; Pub.L. 105-33, Title IV, §§ 4702(a), 4711(c)(1), 4712(d)(1), 4714(a)(2), 4725(b)(1), 4732(b), 4802(a)(1), 4911(a), Aug. 5, 1997, 111 Stat. 494, 508, 509, 510, 518, 520, 538, 570; Pub.L. 105-100, Title I, § 162(1), (2), Nov. 19, 1997, 111 Stat. 2188; Pub.L. 106-113, Div. B, § 1000(a)(6) [Title VI, §§ 605(a), 608(l), (m), (aa)(3), Nov. 29, 1999, 113 Stat. 1536, 1501A-396, 1501A-397, 1501A-398; Pub.L. 106-169, Title I, § 121(a)(2), (c)(1), Dec. 14, 1999, 113 Stat. 1829; Pub.L. 106-170, Title II, § 201(a)(2)((B),(C), Dec. 17, 1999, 113 Stat. 1894; Pub.L. 106-354, § 2(a)(4), (c), Oct. 24, 2000, 114 Stat. 1382, 1384; Pub.L. 106-554, § 1(a)(6) [Title VII, § 709, Title VIII, § 802(d)(1), (2), Title IX, § 911(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-578, 2763A-581, 2763A-584; Pub.L. 108-357, Title VII, § 712(a)(1), Oct. 22, 2004, 118 Stat. 1558; Pub.L. 109-171, Title VI, § 6062(c)(2), Feb. 8, 2006, 120 Stat. 98; Pub.L. 110-275, Title I, §§ 112, 118(a), July 15, 2008, 122 Stat. 2503, 2507; Pub.L. 111-148, Title II, §§ 2001(a)(3), (5)(C), (e)(2)(A), 2005(c)(1), 2006, 2301(a), 2302(a), 2303(a)(4)(A), 2304, 2402(d)(2)(B), Title IV, §§ 4106(a), (b), 4107(a), Title X, § 10201(c), Mar. 23, 2010, 124 Stat. 272, 275, 279, 284, 292 to 294, 296, 304, 559, 560, 918; Pub.L. 111-152, Title I, §§ 1201, 1202(b), Mar. 30, 2010, 124 Stat. 1051, 1053; Pub.L. 112-96, Title III, § 3204(a), Feb. 22, 2012, 126 Stat. 193; Pub.L. 112-141, Div. F, Title I, § 100123(b), July 6, 2012, 126 Stat. 915; Pub.L. 114-255, Div. B, Title XII, § 12005(a), Dec. 13, 2016, 130 Stat. 1275.)

Notes of Decisions (94)

Footnotes

1 So in original. Probably means the subsec. (aa) of 42 U.S.C.A. § 1396a relating to certain breast or cervical cancer patients.

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

3 So in original. Clause (ii), was redesignated as cl. (iii) by Pub.L. 101-508, Title IV, § 4704(c)(3), Nov. 5, 1990, 104 Stat. 1388-172.

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

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

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

7 So in original.

[8]

So in original. Probably should read "section 1397ee(b) of this title".

42 U.S.C.A. § 1396d, 42 USCA § 1396d
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

End of Document

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedLimited on Preemption Grounds by Molinelli-Freytes v. University of Puerto Rico, D.Puerto Rico, July 27, 2010
KeyCite Yellow Flag - Negative TreatmentProposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 21. Civil Rights (Refs & Annos)
Subchapter I. Generally

42 U.S.C.A. § 1983

§ 1983. Civil action for deprivation of rights

Effective: October 19, 1996

Currentness

<Notes of Decisions for 42 USCA § 1983 are displayed in six separate documents. Notes of Decisions for subdivisions I to IX are contained in this document. For additional Notes of Decisions, see 42 § 1983, ante.>

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

CREDIT(S)

(R.S. § 1979; Pub.L. 96-170, § 1, Dec. 29, 1979, 93 Stat. 1284; Pub.L. 104-317, Title III, § 309(c), Oct. 19, 1996, 110 Stat. 3853.)

Notes of Decisions (5820)

42 U.S.C.A. § 1983, 42 USCA § 1983
Current through P.L. 115-140. Title 26 includes updates from P.L. 115-141, Divisions M, T, and U (Titles I through III).

End of Document

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Federal Rules of Civil Procedure for the United States District Courts (Refs & Annos)
Title IV. Parties

Federal Rules of Civil Procedure Rule 23

Rule 23. Class Actions

Currentness

<Notes of Decisions for 28 USCA Federal Rules of Civil Procedure Rule 23 are displayed in two separate documents. Notes of Decisions for subdivisions I and II are contained in this document. For Notes of Decisions for subdivisions III to end, see second document for 28 USCA Federal Rules of Civil Procedure Rule 23.>

(a) Prerequisites. One or more members of a class may sue or be sued as representative parties on behalf of all members only if:

(1) the class is so numerous that joinder of all members is impracticable;

(2) there are questions of law or fact common to the class;

(3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and

(4) the representative parties will fairly and adequately protect the interests of the class.

(b) Types of Class Actions. A class action may be maintained if Rule 23(a) is satisfied and if:

(1) prosecuting separate actions by or against individual class members would create a risk of:

(A) inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class; or

(B) adjudications with respect to individual class members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests;

(2) the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole; or

(3) the court finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy. The matters pertinent to these findings include:

(A) the class members' interests in individually controlling the prosecution or defense of separate actions;

(B) the extent and nature of any litigation concerning the controversy already begun by or against class members;

(C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; and

(D) the likely difficulties in managing a class action.

(c) Certification Order; Notice to Class Members; Judgment; Issues Classes; Subclasses.

(1) ***Certification Order.***

(A) *Time to Issue.* At an early practicable time after a person sues or is sued as a class representative, the court must determine by order whether to certify the action as a class action.

(B) *Defining the Class; Appointing Class Counsel.* An order that certifies a class action must define the class and the class claims, issues, or defenses, and must appoint class counsel under Rule 23(g).

(C) *Altering or Amending the Order.* An order that grants or denies class certification may be altered or amended before final judgment.

(2) ***Notice.***

(A) *For (b)(1) or (b)(2) Classes.* For any class certified under Rule 23(b)(1) or (b)(2), the court may direct appropriate notice to the class.

(B) *For (b)(3) Classes.* For any class certified under Rule 23(b)(3), the court must direct to class members the best notice that is practicable under the circumstances, including individual notice to all members who can be identified through reasonable effort. The notice must clearly and concisely state in plain, easily understood language:

(i) the nature of the action;

(ii) the definition of the class certified;

(iii) the class claims, issues, or defenses;

(iv) that a class member may enter an appearance through an attorney if the member so desires;

(v) that the court will exclude from the class any member who requests exclusion;

(vi) the time and manner for requesting exclusion; and

(vii) the binding effect of a class judgment on members under Rule 23(c)(3).

(3) ***Judgment.*** Whether or not favorable to the class, the judgment in a class action must:

(A) for any class certified under Rule 23(b)(1) or (b)(2), include and describe those whom the court finds to be class members; and

(B) for any class certified under Rule 23(b)(3), include and specify or describe those to whom the Rule 23(c)(2) notice was directed, who have not requested exclusion, and whom the court finds to be class members.

(4) ***Particular Issues.*** When appropriate, an action may be brought or maintained as a class action with respect to particular issues.

(5) ***Subclasses.*** When appropriate, a class may be divided into subclasses that are each treated as a class under this rule.

(d) Conducting the Action.

(1) ***In General.*** In conducting an action under this rule, the court may issue orders that:

(A) determine the course of proceedings or prescribe measures to prevent undue repetition or complication in presenting evidence or argument;

(B) require--to protect class members and fairly conduct the action--giving appropriate notice to some or all class members of:

(i) any step in the action;

(ii) the proposed extent of the judgment; or

(iii) the members' opportunity to signify whether they consider the representation fair and adequate, to intervene and present claims or defenses, or to otherwise come into the action;

(C) impose conditions on the representative parties or on intervenors;

(D) require that the pleadings be amended to eliminate allegations about representation of absent persons and that the action proceed accordingly; or

(E) deal with similar procedural matters.

(2) ***Combining and Amending Orders.*** An order under Rule 23(d)(1) may be altered or amended from time to time and may be combined with an order under Rule 16.

(e) Settlement, Voluntary Dismissal, or Compromise. The claims, issues, or defenses of a certified class may be settled, voluntarily dismissed, or compromised only with the court's approval. The following procedures apply to a proposed settlement, voluntary dismissal, or compromise:

(1) The court must direct notice in a reasonable manner to all class members who would be bound by the proposal.

(2) If the proposal would bind class members, the court may approve it only after a hearing and on finding that it is fair, reasonable, and adequate.

(3) The parties seeking approval must file a statement identifying any agreement made in connection with the proposal.

(4) If the class action was previously certified under Rule 23(b)(3), the court may refuse to approve a settlement unless it affords a new opportunity to request exclusion to individual class members who had an earlier opportunity to request exclusion but did not do so.

(5) Any class member may object to the proposal if it requires court approval under this subdivision (e); the objection may be withdrawn only with the court's approval.

(f) Appeals. A court of appeals may permit an appeal from an order granting or denying class-action certification under this rule if a petition for permission to appeal is filed with the circuit clerk within 14 days after the order is entered. An appeal does not stay proceedings in the district court unless the district judge or the court of appeals so orders.

(g) Class Counsel.

(1) ***Appointing Class Counsel.*** Unless a statute provides otherwise, a court that certifies a class must appoint class counsel. In appointing class counsel, the court:

(A) must consider:

(i) the work counsel has done in identifying or investigating potential claims in the action;

(ii) counsel's experience in handling class actions, other complex litigation, and the types of claims asserted in the action;

(iii) counsel's knowledge of the applicable law; and

(iv) the resources that counsel will commit to representing the class;

(B) may consider any other matter pertinent to counsel's ability to fairly and adequately represent the interests of the class;

(C) may order potential class counsel to provide information on any subject pertinent to the appointment and to propose terms for attorney's fees and nontaxable costs;

(D) may include in the appointing order provisions about the award of attorney's fees or nontaxable costs under Rule 23(h); and

(E) may make further orders in connection with the appointment.

(2) ***Standard for Appointing Class Counsel.*** When one applicant seeks appointment as class counsel, the court may appoint that applicant only if the applicant is adequate under Rule 23(g)(1) and (4). If more than one adequate applicant seeks appointment, the court must appoint the applicant best able to represent the interests of the class.

(3) ***Interim Counsel.*** The court may designate interim counsel to act on behalf of a putative class before determining whether to certify the action as a class action.

(4) ***Duty of Class Counsel.*** Class counsel must fairly and adequately represent the interests of the class.

(h) Attorney's Fees and Nontaxable Costs. In a certified class action, the court may award reasonable attorney's fees and nontaxable costs that are authorized by law or by the parties' agreement. The following procedures apply:

(1) A claim for an award must be made by motion under Rule 54(d)(2), subject to the provisions of this subdivision (h), at a time the court sets. Notice of the motion must be served on all parties and, for motions by class counsel, directed to class

members in a reasonable manner.

(2) A class member, or a party from whom payment is sought, may object to the motion.

(3) The court may hold a hearing and must find the facts and state its legal conclusions under Rule 52(a).

(4) The court may refer issues related to the amount of the award to a special master or a magistrate judge, as provided in Rule 54(d)(2)(D).

CREDIT(S)

(Amended February 28, 1966, effective July 1, 1966; March 2, 1987, effective August 1, 1987; April 24, 1998, effective December 1, 1998; March 27, 2003, effective December 1, 2003; April 30, 2007, effective December 1, 2007; March 26, 2009, effective December 1, 2009.)

ADVISORY COMMITTEE NOTES

1937 Adoption

Note to Subdivision (a). This is a substantial restatement of [former] Equity Rule 38 (Representatives of Class) as that rule has been construed. It applies to all actions, whether formerly denominated legal or equitable. For a general analysis of class actions, effect of judgment, and requisites of jurisdiction see Moore, *Federal Rules of Civil Procedure: Some Problems Raised by the Preliminary Draft,* 25 Georgetown L.J. 551, 570 et seq. (1937); Moore and Cohn, *Federal Class Actions,* 32 Ill.L.Rev. 307 (1937); Moore and Cohn, *Federal Class Actions--Jurisdiction and Effect of Judgment,* 32 Ill.L.Rev. 555-567 (1938); Lesar, *Class Suits and the Federal Rules,* 22 Minn.L.Rev. 34 (1937); cf. Arnold and James, *Cases on Trials, Judgments and Appeals* (1936) 175; and see Blume, *Jurisdictional Amount in Representative Suits,* 15 Minn.L.Rev. 501 (1931).

The general test of [former] Equity Rule 38 (Representatives of Class) that the question should be "one of common or general interest to many persons constituting a class so numerous as to make it impracticable to bring them all before the court," is a common test. For states which require the two elements of a common or general interest and numerous persons, as provided for in [former] Equity Rule 38, see Del.Ch. Rule 113; Fla.Comp.Gen.Laws Ann. (Supp., 1936) § 4918(7); Georgia Code (1933) § 37-1002, and see *English Rules Under the Judicature Act* (The Annual Practice, 1937) O. 16, r. 9. For statutory provisions providing for class actions when the question is one of common or general interest or when the parties are numerous, see Ala.Code Ann. (Michie, 1928) § 5701; 2 Ind.Stat.Ann. (Burns, 1933) § 2-220; N.Y.C.P.A. (1937) 195; Wis.Stat. (1935) § 260.12. These statutes have, however, been uniformly construed as though phrased in the conjunctive. See *Garfein v. Stiglitz,* 260 Ky. 430, 86 S.W.2d 155 (1935). The rule adopts the test of [former] Equity Rule 38, but defines what constitutes a "common or general interest". Compare with code provisions which make the action dependent upon the propriety of joinder of the parties. See Blume, *The "Common Questions" Principle in the Code Provision for Representative Suits,* 30 Mich.L.Rev. 878 (1932). For discussion of what constitutes "numerous persons" see Wheaton, *Representative Suits Involving Numerous Litigants,* 19 Corn.L.Q. 399 (1934); Note, 36 Harv.L.Rev. 89 (1922).

Clause (1), Joint, Common, or Secondary Right. This clause is illustrated in actions brought by or against representatives

of an unincorporated association. See *Oster v. Brotherhood of Locomotive Firemen and Enginemen*, 271 Pa. 419, 114 Atl. 377 (1921); *Pickett v. Walsh*, 192 Mass. 572, 78 N.E. 753, 6 L.R.A., N.S., 1067 (1906); *Colt v. Hicks*, 97 Ind.App. 177, 179 N.E. 335 (1932). Compare Rule 17(b) as to when an unincorporated association has capacity to sue or be sued in its common name; *United Mine Workers of America v. Coronado Coal Co.*, 42 S.Ct. 570, 259 U.S. 344, 66 L.Ed. 975, 27 A.L.R. 762 (1922) (an unincorporated association was sued as an entity for the purpose of enforcing against it a federal substantive right); Moore, *Federal Rules of Civil Procedure: Some Problems Raised by the Preliminary Draft*, 25 Georgetown L.J. 551, 566 (for discussion of jurisdictional requisites when an unincorporated association sues or is sued in its common name and jurisdiction is founded upon diversity of citizenship). For an action brought by representatives of one group against representatives of another group for distribution of a fund held by an unincorporated association, see *Smith v. Swormstedt*, 16 How. 288, 14 L.Ed. 942 (U.S. 1853). Compare *Christopher, et al. v. Brusselback*, 1938, 58 S.Ct. 350, 302 U.S. 500, 82 L.Ed. 388.

For an action to enforce rights held in common by policyholders against the corporate issuer of the policies, see *Supreme Tribe of Ben Hur v. Cauble*, 255 U.S. 356, 41 S.Ct. 338, 65 L.Ed. 673 (1921). See also *Terry v. Little*, 101 U.S. 216, 25 L.Ed. 864 (1880); *John A. Roebling's Sons Co. v. Kinnicutt*, 248 Fed. 596 (D.C.N.Y., 1917) dealing with the right held in common by creditors to enforce the statutory liability of stockholders.

Typical of a secondary action is a suit by stockholders to enforce a corporate right. For discussion of the general nature of these actions see *Ashwander v. Tennessee Valley Authority*, 297 U.S. 288, 56 S.Ct. 466, 80 L.Ed. 688 (1936); Glenn, *The Stockholder's Suit--Corporate and Individual Grievances*, 33 Yale L.J. 580 (1924); McLaughlin, *Capacity of Plaintiff-Stockholder to Terminate a Stockholder's Suit*, 46 Yale L.J. 421 (1937). See also Subdivision (b) of this rule which deals with Shareholder's Action; Note, 15 Minn.L.Rev. 453 (1931).

Clause (2). A creditor's action for liquidation or reorganization of a corporation is illustrative of this clause. An action by a stockholder against certain named defendants as representatives of numerous claimants presents a situation converse to the creditor's action.

Clause (3). See *Everglades Drainage League v. Napoleon Broward Drainage Dist.*, 253 Fed. 246 (D.C.Fla., 1918); *Gramling v. Maxwell*, 52 F.2d 256 (D.C.N.C., 1931), approved in 30 Mich.L.Rev. 624 (1932); *Skinner v. Mitchell*, 108 Kan. 861, 197 Pac. 569 (1921); *Duke of Bedford v. Ellis* (1901) A.C. 1, for class actions when there were numerous persons and there was only a question of law or fact common to them; and see Blume, *The "Common Questions" Principle in the Code Provision for Representative Suits*, 30 Mich.L.Rev. 878 (1932).

Note to Subdivision (b). This is [former] Equity Rule 27 (Stockholder's Bill) with verbal changes. See also *Hawes v. Oakland*, 104 U.S. 450, 26 L.Ed. 827 (1882) and former Equity Rule 94, promulgated January 23, 1882, 104 U.S. IX.

Note to Subdivision (c). See McLaughlin, Capacity of Plaintiff-Stockholder to Terminate a Stockholder's Suit, 46 Yale L.J. 421 (1937).

Supplementary Note

Note. Subdivision (b), relating to secondary actions by shareholders, provides among other things, that in such an action the complainant "shall aver (1) that the plaintiff was a shareholder at the time of the transaction of which he complains or that his share thereafter devolved on him by operation of law * * *."

As a result of the decision in *Erie R. Co. v. Tompkins*, 1938, 304 U.S. 64, 58 S.Ct. 817 (decided April 25, 1938, after this rule was promulgated by the Supreme Court, though before it took effect) a question has arisen as to whether the provision above quoted deals with a matter of substantive right or is a matter of procedure. If it is a matter of substantive law or right, then under *Erie R. Co. v. Tompkins* clause (1) may not be validly applied in cases pending in states whose local law permits a shareholder to maintain such actions, although not a shareholder at the time of the transactions complained of. The Advisory Committee, believing the question should be settled in the courts, proposes no change in Rule 23 but thinks rather that the situation should be explained in an appropriate note.

The rule has a long history. In *Hawes v. Oakland*, 1882, 104 U.S. 450, the Court held that a shareholder could not maintain such an action unless he owned shares at the time of the transactions complained of, or unless they devolved on him by operation of law. At that time the decision in *Swift v. Tyson*, 1842, 16 Peters 1, was the law, and the federal courts considered themselves free to establish their own principles of equity jurisprudence, so the Court was not in 1882 and has not been, until *Erie R. Co. v. Tompkins* in 1938, concerned with the question whether *Hawes v. Oakland* dealt with substantive right or procedure.

Following the decision in *Hawes v. Oakland*, and at the same term, the Court, to implement its decision, adopted [former] Equity Rule 94, which contained the same provision above quoted from Rule 23 F.R.C.P. The provision in [former] Equity Rule 94 was later embodied in [former] Equity Rule 27, of which the present Rule 23 is substantially a copy.

In *City of Quincy v. Steel*, 1887, 120 U.S. 241, 245, 7 S.Ct. 520, the Court referring to *Hawes v. Oakland* said: "In order to give effect to the principles there laid down, this Court at that term adopted Rule 94 of the rules of practice for courts of equity of the United States."

Some other cases dealing with [former] Equity Rules 94 or 27 prior to the decision in *Erie R. Co. v. Tompkins* are *Dimpfel v. Ohio & Miss. R.R.*, 1884, 3 S.Ct. 573, 110 U.S. 209, 28 L.Ed. 121; *Illinois Central R. Co. v. Adams*, 1901, 21 S.Ct. 251, 180 U.S. 28, 34, 45L.Ed. 410; *Venner v. Great Northern Ry.*, 1908, 28 S.Ct. 328, 209 U.S. 24, 30, 52 L.Ed. 666; *Jacobson v. General Motors Corp.*, S.D.N.Y.1938, 22 F.Supp. 255, 257. These cases generally treat *Hawes v. Oakland* as establishing a "principle" of equity, or as dealing not with jurisdiction but with the "right" to maintain an action, or have said that the defense under the equity rule is analogous to the defense that the plaintiff has no "title" and results in a dismissal "for want of equity."

Those state decisions which held that a shareholder acquiring stock after the event may maintain a derivative action are founded on the view that it is a right belonging to the shareholder at the time of the transaction and which passes as a right to the subsequent purchaser. See *Pollitz v. Gould*, 1911, 202 N.Y. 11, 94 N.E. 1088.

The first case arising after the decision in *Erie R. Co. v. Tompkins*, in which this problem was involved, was *Summers v. Hearst*, S.D.N.Y.1938, 23 F.Supp. 986. It concerned [former] Equity Rule 27, as Federal Rule 23 was not then in effect. In a well considered opinion Judge Leibell reviewed the decisions and said: "The federal cases that discuss this section of [former] Rule 27 support the view that it states a principle of substantive law." He quoted *Pollitz v. Gould*, 1911, 202 N.Y. 11, 94 N.E. 1088, as saying that the United States Supreme Court "seems to have been more concerned with establishing this rule as one of practice than of substantive law" but that "whether it be regarded as establishing a principle of law or a rule of practice, this authority has been subsequently followed in the United States courts."

He then concluded that, although the federal decisions treat the equity rule as "stating a principle of substantive law", if "[former] Equity Rule 27 is to be modified or revoked in view of *Erie R. Co. v. Tompkins*, it is not the province of this Court to suggest it, much less impliedly to follow that course by disregarding the mandatory provisions of the Rule."

In *Piccard v. Sperry Corporation,* S.D.N.Y.1941, 36 F.Supp. 1006, 1009-10, affirmed without opinion, C.C.A.2d 1941, 120 F.2d 328, a shareholder, not such at the time of the transactions complained of, sought to intervene. The court held an intervenor was as much subject to Rule 23 as an original plaintiff; and that the requirement of Rule 23(b) was "a matter of practice," not substance, and applied in New York where the state law was otherwise, despite *Erie R. Co. v. Tompkins.* In *New York v. Guaranty Trust Co. of New York,* C.C.A.2, 1944, 143 F.2d 503, rev'd on other grounds, 1945, 65 S.Ct. 1464, the court said: "Restrictions on the bringing of stockholders' actions, such as those imposed by F.R.C.P. 23(b) or other state statutes are procedural," citing the *Piccard* and other cases.

Some other federal decisions since 1938 touch the question.

In *Gallup v. Caldwell,* C.C.A.3, 1941, 120 F.2d 90, 95 arising in New Jersey, the point was raised but not decided, the court saying that it was not satisfied that the then New Jersey rule differed from Rule 23(b), and that "under the circumstances the proper course was to follow Rule 23(b)."

In *Mullins v. DeSoto Securities Co.,* W.D.La.1942, 45 F.Supp. 871, 878, the point was not decided, because the court found the Louisiana rule to be the same as that stated in Rule 23(b).

In *Toebelman v. Missouri-Kansas Pipe Line Co.,* D.Del.1941, 41 F.Supp. 334, 340, the court dealt only with another part of Rule 23(b), relating to prior demands on the stockholders and did not discuss *Erie R. Co. v. Tompkins,* or its effect on the rule.

In *Perrott v. United States Banking Corp.,* D.Del.1944, 53 F.Supp. 953, it appeared that the Delaware law does not require the plaintiff to have owned shares at the time of the transaction complained of. The court sustained Rule 23(b), after discussion of the authorities, saying:

"It seems to me the rule does not go beyond procedure. * * * Simply because a particular plaintiff cannot qualify as a proper party to maintain such an action does not destroy or even whittle at the cause of action. The cause of action exists until a qualified plaintiff can get it started in a federal court."

In *Bankers Nat. Corp. v. Barr,* S.D.N.Y.1945, 9 Fed.Rules Serv. 23b.11, Case 1, the court held Rule 23(b) to be one of procedure, but that whether the plaintiff was a stockholder was a substantive question to be settled by state law.

The New York rule, as stated in *Pollitz v. Gould,* supra, has been altered by an act of the New York Legislature, Chapter 667, Laws of 1944, effective April 9, 1944, General Corporation Law, § 61, which provides that "in any action brought by a shareholder in the right of a * * * corporation, it must appear that the plaintiff was a stockholder at the time of the transaction of which he complains, or that his stock thereafter devolved upon him by operation of law." At the same time a further and separate provision was enacted, requiring under certain circumstances the giving of security for reasonable expenses and attorney's fees, to which security the corporation in whose right the action is brought and the defendants therein may have recourse. (Chapter 668, Laws of 1944, effective April 9, 1944, General Corporation Law, § 61-b.) These provisions are aimed at so-called "strike" stockholders' suits and their attendant abuses. *Shielcrawt v. Moffett,* Ct.App.1945, 294 N.Y. 180, 61 N.E.2d 435, rev'g 51 N.Y.S.2d 188, aff'g 49 N.Y.S.2d 64; *Noel Associates, Inc. v. Merrill,* Sup.Ct.1944, 184 Misc. 646, 63 N.Y.S.2d 143.

Insofar as § 61 is concerned, it has been held that the section is procedural in nature. *Klum v. Clinton Trust Co.,* Sup.Ct.1944,

183 Misc. 340, 48 N.Y.S.2d 267; *Noel Associates, Inc. v. Merrill*, supra. In the latter case the court pointed out that "The 1944 amendment to Section 61 rejected the rule laid down in the Pollitz case and substituted, in place thereof, in its precise language, the rule which has long prevailed in the Federal Courts and which is now Rule 23(b) * * *." There is, nevertheless, a difference of opinion regarding the application of the statute to pending actions. See *Klum v. Clinton Trust Co.*, supra (applicable); *Noel Associates, Inc. v. Merrill*, supra (inapplicable).

With respect to § 61-b, which may be regarded as a separate problem, *Noel Associates, Inc. v. Merrill*, supra, it has been held that even though the statute is procedural in nature--a matter not definitely decided--the Legislature evinced no intent that the provisions should apply to actions pending when it became effective. *Shielcrawt v. Moffett*, supra. As to actions instituted after the effective date of the legislation, the constitutionality of § 61-b is in dispute. See *Wolf v. Atkinson*, Sup.Ct.1944, 182 Misc. 675, 49 N.Y.S.2d 703 (constitutional); *Citron v. Mangel Stores Corp.*, Sup.Ct.1944, 50 N.Y.S.2d 416 (unconstitutional); Zlinkoff, *The American Investor and the Constitutionality of § 61-b of the New York General Corporation Law*, 1945, 54 Yale L.J. 352.

New Jersey also enacted a statute, similar to Chapters 667 and 668 of the New York law. See P.L.1945, Ch. 131, R.S.Cum.Supp. 14:3-15. The New Jersey provision similar to Chapter 668, § 61-b, differs, however, in that it specifically applies retroactively. It has been held that this provision is procedural and hence will not govern a pending action brought against a New Jersey corporation in the New York courts. *Shielcrawt v. Moffett*, Sup.Ct.N.Y.1945, 184 Misc. 1074, 56 N.Y.S.2d 134.

See, also generally, 2 Moore's *Federal Practice*, 1938, 2250-2253, and Cum.Supplement § 23.05.

The decisions here discussed show that the question is a debatable one, and that there is respectable authority for either view, with a recent trend towards the view that Rule 23(b)(1) is procedural. There is reason to say that the question is one which should not be decided by the Supreme Court ex parte, but left to await a judicial decision in a litigated case, and that in the light of the material in this note, the only inference to be drawn from a failure to amend Rule 23(b) would be that the question is postponed to await a litigated case.

The Advisory Committee is unanimously of the opinion that this course should be followed.

If, however, the final conclusion is that the rule deals with a matter of substantive right, then the rule should be amended by adding a provision that Rule 23(b)(1) does not apply in jurisdictions where state law permits a shareholder to maintain a secondary action, although he was not a shareholder at the time of the transactions of which he complains.

1966 Amendment

Difficulties with the original rule. The categories of class actions in the original rule were defined in terms of the abstract nature of the rights involved: the so-called "true" category was defined as involving "joint, common, or secondary rights"; the "hybrid" category, as involving "several" rights related to "specific property"; the "spurious" category, as involving "several" rights affected by a common question and related to common relief. It was thought that the definitions accurately described the situations amenable to the class-suit device, and also would indicate the proper extent of the judgment in each category, which would in turn help to determine the res judicata effect of the judgment if questioned in a later action. Thus the judgments in "true" and "hybrid" class actions would extend to the class (although in somewhat different ways); the judgment in a "spurious" class action would extend only to the parties including intervenors. See Moore, *Federal Rules of Civil Procedure: Some Problems Raised by the Preliminary Draft*, 25 Geo.L.J. 551, 570-76 (1937).

In practice the terms "joint," "common," etc., which were used as the basis of the Rule 23 classification proved obscure and uncertain. See Chafee, *Some Problems of Equity* 245-46, 256-57 (1950); Kalven & Rosenfield, *The Contemporary Function of the Class Suit,* 8 U. of Chi.L.Rev. 684, 707 & n. 73 (1941); Keeffe, Levy & Donovan, *Lee Defeats Ben Hur,* 33 Corn.L.Q. 327, 329-36 (1948); *Developments in the Law: Multiparty Litigation in the Federal Courts,* 71 Harv. L.Rev. 874, 931 (1958); Advisory Committee's Note to Rule 19, as amended. The courts had considerable difficulty with these terms. See, e.g., *Gullo v. Veterans' Coop. H. Assn.,* 13 F.R.D. 11 (D.D.C.1952); *Shipley v. Pittsburgh & L.E.R. Co.,* 70 F.Supp. 870 (W.D.Pa.1947); *Deckert v. Independence Shares Corp.,* 27 F.Supp. 763 (E.D.Pa.1939), rev'd 108 F.2d 51 (3d Cir. 1939), rev'd, 311 U.S. 282 (1940), on remand, 39 F.Supp. 592 (E.D.Pa.1941), rev'd sub nom. *Pennsylvania Co. for Ins. on Lives v. Deckert,* 123 F.2d 979 (3d Cir.1941) (see Chafee, supra, at 264-65).

Nor did the rule provide an adequate guide to the proper extent of the judgments in class actions. First, we find instances of the courts classifying actions as "true" or intimating that the judgments would be decisive for the class where these results seemed appropriate but were reached by dint of depriving the word "several" of coherent meaning. See, e.g., *System Federation No. 91 v. Reed,* 180 F.2d 991 (6th Cir.1950); *Wilson v. City of Paducah,* 100 F.Supp. 116 (W.D.Ky.1951); *Citizens Banking Co. v. Monticello State Bank,* 143 F.2d 261 (8th Cir.1944); *Redmond v. Commerce Trust Co.,* 144 F.2d 140 (8th Cir.1944), cert. denied, 323 U.S. 776 (1944); *United States v. American Optical Co.,* 97 F.Supp. 66 (N.D.Ill.1951); *National Hairdressers' & C. Assn. v. Philad Co.,* 34 F.Supp. 264 (D.Del.1940); 41 F.Supp. 701 (D.Del.1940), aff'd mem., 129 F.2d 1020 (3d Cir.1942). Second, we find cases classified by the courts as "spurious" in which, on a realistic view, it would seem fitting for the judgments to extend to the class. See, e.g., *Knapp v. Bankers Sec. Corp.,* 17 F.R.D. 245 (E.D.Pa.1954), aff'd 230 F.2d 717 (3d Cir.1956); *Giesecke v. Denver Tramway Corp.,* 81 F.Supp. 957 (D.Del.1949); *York v. Guaranty Trust Co.,* 143 F.2d 503 (2d Cir.1944), rev'd on grounds not here relevant, 326 U.S. 99 (1945) (see Chafee, supra, at 208); cf. *Webster Eisenlohr, Inc. v. Kalodner,* 145 F.2d 316, 320 (3d Cir.1944), cert. denied, 325 U.S. 867 (1945). But cf. the early decisions, *Duke of Bedford v. Ellis,* [1901] A.C. 1; *Sheffield Waterworks v. Yeomans,* L.R. 2 Ch.App. 8 (1866); *Brown v. Vermuden,* 1 Ch.Cas. 272, 22 Eng.Rep. 796 (1676).

The "spurious" action envisaged by original Rule 23 was in any event an anomaly because, although denominated a "class" action and pleaded as such, it was supposed not to adjudicate the rights or liabilities of any person not a party. It was believed to be an advantage of the "spurious" category that it would invite decisions that a member of the "class" could, like a member of the class in a "true" or "hybrid" action, intervene on an ancillary basis without being required to show an independent basis of Federal jurisdiction, and have the benefit of the date of the commencement of the action for purposes of the statute of limitations. See 3 Moore's *Federal Practice,* pars. 23.10[1], 23.12 (2d ed.1963). These results were attained in some instances but not in others. On the statute of limitations, see *Union Carbide & Carbon Corp. v. Nisley,* 300 F.2d 561 (10th Cir.1961), pet. cert. dism., 371 U.S. 801 (1963); but cf. *P. W. Husserl, Inc. v. Newman,* 25 F.R.D. 264 (S.D.N.Y.1960); *Athas v. Day,* 161 F.Supp. 916 (D.Colo.1958). On ancillary intervention, see *Amen v. Black,* 234 F.2d 12 (10th Cir.1956), cert. granted, 352 U.S. 888 (1956), dism. on stip., 355 U.S. 600 (1958); but cf. *Wagner v. Kemper,* 13 F.R.D. 128 (W.D.Mo.1952). The results, however, can hardly depend upon the mere appearance of a "spurious" category in the rule; they should turn on more basic considerations. See discussion of subdivision (c)(1) below.

Finally, the original rule did not squarely address itself to the question of the measures that might be taken during the course of the action to assure procedural fairness, particularly giving notice to members of the class, which may in turn be related in some instances to the extension of the judgment to the class. See Chafee, supra, at 230-31; Keeffe, Levy & Donovan, supra; *Developments in the law,* supra, 71 Harv.L.Rev. at 937-38; Note, *Binding Effect of Class Actions,* 67 Harv.L.Rev. 1059, 1062-65 (1954); Note, *Federal Class Actions: A Suggested Revision of Rule 23,* 46 Colum.L.Rev. 818, 833-36 (1946); Mich.Gen.Court R. 208.4 (effective Jan. 1, 1963); Idaho R.Civ.P. 23(d); Minn.R.Civ.P. 23.04; N.Dak.R.Civ.P. 23(d).

The amended rule describes in more practical terms the occasions for maintaining class actions; provides that all class actions maintained to the end as such will result in judgments including those whom the court finds to be members of the class, whether or not the judgment is favorable to the class; and refers to the measures which can be taken to assure the fair conduct of these actions.

Subdivision (a) states the prerequisites for maintaining any class action in terms of the numerousness of the class making joinder of the members impracticable, the existence of questions common to the class, and the desired qualifications of the representative parties. See Weinstein, *Revision of Procedure: Some Problems in Class Actions,* 9 Buffalo L.Rev. 433, 458-59 (1960); 2 Barron & Holtzoff, *Federal Practice & Procedure* § 562, at 265, § 572, at 351-52 (Wright ed. 1961). These are necessary but not sufficient conditions for a class action. See, e.g., *Giordano v. Radio Corp. of Am.,* 183 F.2d 558, 560 (3d Cir.1950); *Zachman v. Erwin,* 186 F.Supp. 681 (S.D.Tex.1959); *Baim & Blank, Inc. v. Warren-Connelly Co., Inc.,* 19 F.R.D. 108 (S.D.N.Y.1956). Subdivision (b) describes the additional elements which in varying situations justify the use of a class action.

Subdivision (b)(1). The difficulties which would be likely to arise if resort were had to separate actions by or against the individual members of the class here furnish the reasons for, and the principal key to, the propriety and value of utilizing the class-action device. The considerations stated under clauses (A) and (B) are comparable to certain of the elements which define the persons whose joinder in an action is desirable as stated in Rule 19(a), as amended. See amended Rule 19(a)(2)(i) and (ii), and the Advisory Committee's Note thereto; Hazard, *Indispensable Party: The Historical Origin of a Procedural Phantom,* 61 Colum.L.Rev. 1254, 1259-60 (1961); cf. 3 Moore, supra, par. 23.08, at 3435.

Clause (A): One person may have rights against, or be under duties toward, numerous persons constituting a class, and be so positioned that conflicting or varying adjudications in lawsuits with individual members of the class might establish incompatible standards to govern his conduct. The class action device can be used effectively to obviate the actual or virtual dilemma which would thus confront the party opposing the class. The matter has been stated thus: "The felt necessity for a class action is greatest when the courts are called upon to order or sanction the alteration of the status quo in circumstances such that a large number of persons are in a position to call on a single person to alter the status quo, or to complain if it is altered, and the possibility exists that [the] actor might be called upon to act in inconsistent ways." Louisell & Hazard, *Pleading and Procedure: State and Federal* 719 (1962); see *Supreme Tribe of Ben-Hur v. Cauble,* 255 U.S. 356, 366-67 (1921). To illustrate: Separate actions by individuals against a municipality to declare a bond issue invalid or condition or limit it, to prevent or limit the making of a particular appropriation or to compel or invalidate an assessment, might create a risk of inconsistent or varying determinations. In the same way, individual litigations of the rights and duties of riparian owners, or of landowners' rights and duties respecting a claimed nuisance, could create a possibility of incompatible adjudications. Actions by or against a class provide a ready and fair means of achieving unitary adjudication. See *Maricopa County Mun. Water Con. Dist. v. Looney,* 219 F.2d 529 (9th Cir.1955); *Rank v. Krug,* 142 F.Supp. 1, 154-59 (S.D.Calif.1956), on app., *State of California v. Rank,* 293 F.2d 340, 348 (9th Cir.1961); *Gart v. Cole,* 263 F.2d 244 (2d Cir.1959), cert. denied 359 U.S. 978 (1959); cf. *Martinez v. Maverick Cty. Water Con. & Imp. Dist.,* 219 F.2d 666 (5th Cir.1955); 3 Moore, supra, par. 23.11[2], at 3458-59.

Clause (B): This clause takes in situations where the judgment in a nonclass action by or against an individual member of the class, while not technically concluding the other members, might do so as a practical matter. The vice of an individual action would lie in the fact that the other members of the class, thus practically concluded, would have had no representation in the lawsuit. In an action by policy holders against a fraternal benefit association attacking a financial reorganization of the society, it would hardly have been practical, if indeed it would have been possible, to confine the effects of a validation of the reorganization to the individual plaintiffs. Consequently a class action was called for with adequate representation of all members of the class. See *Supreme Tribe of Ben-Hur v. Cauble,* 255 U.S. 356 (1921); *Waybright v. Columbian Mut. Life Ins. Co.,* 30 F.Supp. 885 (W.D.Tenn.1939); cf. *Smith v. Swormstedt,* 16 How. (57 U.S.) 288 (1853). For much the same reason actions by shareholders to compel the declaration of a dividend[,] the proper recognition and handling of redemption or pre-emption rights, or the like (or actions by the corporation for corresponding declarations of rights), should ordinarily be conducted as class actions, although the matter has been much obscured by the insistence that each shareholder has an individual claim. See *Knapp v. Bankers Securities Corp.,* 17 F.R.D. 245 (E.D.Pa.1954), aff'd, 230 F.2d 717 (3d Cir.1956); *Giesecke v. Denver Tramway Corp.,* 81 F.Supp. 957 (D.Del.1949); *Zahn v. Transamerica Corp.,* 162 F.2d 36 (3d Cir.1947); *Speed v. Transamerica Corp.,* 100 F.Supp. 461 (D.Del.1951); *Sobel v. Whittier Corp.,* 95 F.Supp. 643 (E.D.Mich.1951), app. dism., 195 F.2d 361 (6th Cir.1952); *Goldberg v. Whittier Corp.,* 111 F.Supp. 382 (E.D.Mich.1953); *Dann v.*

Studebaker-Packard Corp., 288 F.2d 201 (6th Cir.1961); *Edgerton v. Armour & Co.*, 94 F.Supp. 549 (S.D.Calif.1950); *Ames v. Mengel Co.*, 190 F.2d 344 (2d Cir.1951). (These shareholders' actions are to be distinguished from derivative actions by shareholders dealt with in new Rule 23.1). The same reasoning applies to an action which charges a breach of trust by an indenture trustee or other fiduciary similarly affecting the members of a large class of security holders or other beneficiaries, and which requires an accounting or like measures to restore the subject of the trust. See *Boesenberg v. Chicago T. & T. Co.*, 128 F.2d 245 (7th Cir.1942); *Citizens Banking Co. v. Monticello State Bank*, 143 F.2d 261 (8th Cir.1944); *Redmond v. Commerce Trust Co.*, 144 F.2d 140 (8th Cir.1944), cert. denied, 323 U.S. 776 (1944); cf. *York v. Guaranty Trust Co.*, 143 F.2d 503 (2d Cir.1944), rev'd on grounds not here relevant, 326 U.S. 99 (1945).

In various situations an adjudication as to one or more members of the class will necessarily or probably have an adverse practical effect on the interests of other members who should therefore be represented in the lawsuit. This is plainly the case when claims are made by numerous persons against a fund insufficient to satisfy all claims. A class action by or against representative members to settle the validity of the claims as a whole, or in groups, followed by separate proof of the amount of each valid claim and proportionate distribution of the fund, meets the problem. Cf. *Dickinson v. Burnham*, 197 F.2d 973 (2d Cir.1952), cert. denied, 344 U.S. 875 (1952); 3 Moore, supra, at par. 23.09. The same reasoning applies to an action by a creditor to set aside a fraudulent conveyance by the debtor and to appropriate the property to his claim, when the debtor's assets are insufficient to pay all creditors' claims. See *Heffernan v. Bennett & Armour*, 110 Cal.App.2d 564, 243 P.2d 846 (1952); cf. *City & County of San Francisco v. Market Street Ry.*, 95 Cal.App.2d 648, 213 P.2d 780 (1950). Similar problems, however, can arise in the absence of a fund either present or potential. A negative or mandatory injunction secured by one of a numerous class may disable the opposing party from performing claimed duties toward the other members of the class or materially affect his ability to do so. An adjudication as to movie "clearances and runs" nominally affecting only one exhibitor would often have practical effects on all the exhibitors in the same territorial area. Cf. *United States v. Paramount Pictures, Inc.*, 66 F.Supp. 323, 341-46 (S.D.N.Y.1946); 334 U.S. 131, 144-48 (1948). Assuming a sufficiently numerous class of exhibitors, a class action would be advisable. (Here representation of subclasses of exhibitors could become necessary; see subdivision (c)(3)(B).)

Subdivision (b)(2). This subdivision is intended to reach situations where a party has taken action or refused to take action with respect to a class, and final relief of an injunctive nature or of a corresponding declaratory nature, settling the legality of the behavior with respect to the class as a whole, is appropriate. Declaratory relief "corresponds" to injunctive relief when as a practical matter it affords injunctive relief or serves as a basis for later injunctive relief. The subdivision does not extend to cases in which the appropriate final relief relates exclusively or predominantly to money damages. Action or inaction is directed to a class within the meaning of this subdivision even if it has taken effect or is threatened only as to one or a few members of the class, provided it is based on grounds which have general application to the class.

Illustrative are various actions in the civil-rights field where a party is charged with discriminating unlawfully against a class, usually one whose members are incapable of specific enumeration. See *Potts v. Flax*, 313 F.2d 284 (5th Cir. 1963); *Bailey v. Patterson*, 323 F.2d 201 (5th Cir. 1963), cert. denied, 376 U.S. 910, (1964); *Brunson v. Board of Trustees of School District No. 1, Clarendon Cty., S.C.*, 311 F.2d 107 (4th Cir. 1962), cert. denied, 373 U.S. 933 (1963); *Green v. School Bd. of Roanoke, Va.*, 304 F.2d 118 (4th Cir. 1962); *Orleans Parish School Bd. v. Bush*, 242 F.2d 156 (5th Cir. 1957), cert. denied, 354 U.S. 921 (1957); *Mannings v. Board of Public Inst. of Hillsborough County, Fla.*, 277 F.2d 370 (5th Cir. 1960); *Northcross v. Board of Ed. of City of Memphis*, 302 F.2d 818 (6th Cir. 1962), cert. denied, 370 U.S. 944 (1962); *Frasier v. Board of Trustees of Univ. of N.C.*, 134 F.Supp. 589 (M.D.N.C.1955, 3-judge court), aff'd 350 U.S. 979 (1956). Subdivision (b)(2) is not limited to civil-rights cases. Thus an action looking to specific or declaratory relief could be brought by a numerous class of purchasers, say retailers of a given description, against a seller alleged to have undertaken to sell to that class at prices higher than those set for other purchasers, say retailers of another description, when the applicable law forbids such a pricing differential. So also a patentee of a machine, charged with selling or licensing the machine on condition that purchasers or licensees also purchase or obtain licenses to use an ancillary unpatented machine, could be sued on a class basis by a numerous group of purchasers or licensees, or by a numerous group of competing sellers or licensors of the unpatented machine, to test the legality of the "tying" condition.

Subdivision (b)(3). In the situations to which this subdivision relates, class-action treatment is not as clearly called for as in those described above, but it may nevertheless be convenient and desirable depending upon the particular facts. Subdivision (b)(3) encompasses those cases in which a class action would achieve economies of time, effort, and expense, and promote uniformity of decision as to persons similarly situated, without sacrificing procedural fairness or bringing about other undesirable results. Cf. Chafee, supra, at 201.

The court is required to find, as a condition of holding that a class action may be maintained under this subdivision, that the questions common to the class predominate over the questions affecting individual members. It is only where this predominance exists that economies can be achieved by means of the class-action device. In this view, a fraud perpetrated on numerous persons by the use of similar misrepresentations may be an appealing situation for a class action, and it may remain so despite the need, if liability is found, for separate determination of the damages suffered by individuals within the class. On the other hand, although having some common core, a fraud case may be unsuited for treatment as a class action if there was material variation in the representations made or in the kinds or degrees of reliance by the persons to whom they were addressed. See *Oppenheimer v. F. J. Young & Co., Inc.,* 144 F.2d 387 (2d Cir. 1944); *Miller v. National City Bank of N.Y.,* 166 F.2d 723 (2d Cir. 1948); and for like problems in other contexts, see *Hughes v. Encyclopaedia Britannica,* 199 F.2d 295 (7th Cir. 1952); *Sturgeon v. Great Lakes Steel Corp.,* 143 F.2d 819 (6th Cir. 1944). A "mass accident" resulting in injuries to numerous persons is ordinarily not appropriate for a class action because of the likelihood that significant questions, not only of damages but of liability and defenses of liability, would be present, affecting the individuals in different ways. In these circumstances an action conducted nominally as a class action would degenerate in practice into multiple lawsuits separately tried. See *Pennsylvania R.R. v. United States,* 111 F.Supp. 80 (D.N.J.1953); cf. Weinstein, supra, 9 Buffalo L.Rev. at 469. Private damage claims by numerous individuals arising out of concerted antitrust violations may or may not involve predominating common questions. See *Union Carbide & Carbon Corp. v. Nisley,* 300 F.2d 561 (10th Cir. 1961), pet. cert. dism., 371 U.S. 801 (1963); cf. *Weeks v. Bareco Oil Co.,* 125 F.2d 84 (7th Cir. 1941); *Kainz v. Anheuser-Busch, Inc.,* 194 F.2d 737 (7th Cir. 1952); *Hess v. Anderson, Clayton & Co.,* 20 F.R.D. 466 (S.D.Calif.1957).

That common questions predominate is not itself sufficient to justify a class action under subdivision (b)(3), for another method of handling the litigious situation may be available which has greater practical advantages. Thus one or more actions agreed to by the parties as test or model actions may be preferable to a class action; or it may prove feasible and preferable to consolidate actions. Cf. Weinstein, supra, 9 Buffalo L.Rev. at 438-54. Even when a number of separate actions are proceeding simultaneously, experience shows that the burdens on the parties and the courts can sometimes be reduced by arrangements for avoiding repetitious discovery or the like. Currently the Coordinating Committee on Multiple Litigation in the United States District Courts (a subcommittee of the Committee on Trial Practice and Technique of the Judicial Conference of the United States) is charged with developing methods for expediting such massive litigation. To reinforce the point that the court with the aid of the parties ought to assess the relative advantages of alternative procedures for handling the total controversy, subdivision (b)(3) requires, as a further condition of maintaining the class action, that the court shall find that that procedure is "superior" to the others in the particular circumstances.

Factors (A)-(D) are listed, non-exhaustively, as pertinent to the findings. The court is to consider the interests of individual members of the class in controlling their own litigations and carrying them on as they see fit. See *Weeks v. Bareco Oil Co.,* 125 F.2d 84, 88-90, 93-94 (7th Cir. 1941) (anti-trust action); see also *Pentland v. Dravo Corp.,* 152 F.2d 851 (3d Cir. 1945), and Chafee, supra, at 273-75, regarding policy of Fair Labor Standards Act of 1938, § 16(b), 29 U.S.C. § 216(b), prior to amendment by Portal-to-Portal Act of 1947, § 5(a). [The present provisions of 29 U.S.C. § 216(b) are not intended to be affected by Rule 23, as amended.]

In this connection the court should inform itself of any litigation actually pending by or against the individuals. The interests of individuals in conducting separate lawsuits may be so strong as to call for denial of a class action. On the other hand, these interests may be theoretic rather than practical; the class may have a high degree of cohesion and prosecution of the action through representatives would be quite unobjectionable, or the amounts at stake for individuals may be so small that separate suits would be impracticable. The burden that separate suits would impose on the party opposing the class, or upon the court calendars, may also fairly be considered. (See the discussion, under subdivision (c)(2) below, of the right of members to be

excluded from the class upon their request.)

Also pertinent is the question of the desirability of concentrating the trial of the claims in the particular forum by means of a class action, in contrast to allowing the claims to be litigated separately in forums to which they would ordinarily be brought. Finally, the court should consider the problems of management which are likely to arise in the conduct of a class action.

Subdivision (c)(1). In order to give clear definition to the action, this provision requires the court to determine, as early in the proceedings as may be practicable, whether an action brought as a class action is to be so maintained. The determination depends in each case on satisfaction of the terms of subdivision (a) and the relevant provisions of subdivision (b).

An order embodying a determination can be conditional; the court may rule, for example, that a class action may be maintained only if the representation is improved through intervention of additional parties of a stated type. A determination once made can be altered or amended before the decision on the merits if, upon fuller development of the facts, the original determination appears unsound. A negative determination means that the action should be stripped of its character as a class action. See subdivision (d)(4). Although an action thus becomes a nonclass action, the court may still be receptive to interventions before the decision on the merits so that the litigation may cover as many interests as can be conveniently handled; the questions whether the intervenors in the nonclass action shall be permitted to claim "ancillary" jurisdiction or the benefit of the date of the commencement of the action for purposes of the statute of limitations are to be decided by reference to the laws governing jurisdiction and limitations as they apply in particular contexts.

Whether the court should require notice to be given to members of the class of its intention to make a determination, or of the order embodying it, is left to the court's discretion under subdivision (d)(2).

Subdivision (c)(2) makes special provision for class actions maintained under subdivision (b)(3). As noted in the discussion of the latter subdivision, the interests of the individuals in pursing their own litigations may be so strong here as to warrant denial of a class action altogether. Even when a class action is maintained under subdivision (b)(3), this individual interest is respected. Thus the court is required to direct notice to the members of the class of the right of each member to be excluded from the class upon his request. A member who does not request exclusion may, if he wishes, enter an appearance in the action through his counsel; whether or not he does so, the judgment in the action will embrace him.

The notice[,] setting forth the alternatives open to the members of the class, is to be the best practicable under the circumstances, and shall include individual notice to the members who can be identified through reasonable effort. (For further discussion of this notice, see the statement under subdivision (d)(2) below.)

Subdivision (c)(3). The judgment in a class action maintained as such to the end will embrace the class, that is, in a class action under subdivision (b)(1) or (b)(2), those found by the court to be class members; in a class action under subdivision (b)(3), those to whom the notice prescribed by subdivision (c)(2) was directed, excepting those who requested exclusion or who are ultimately found by the court not to be members of the class. The judgment has this scope whether it is favorable or unfavorable to the class. In a (b)(1) or (b)(2) action the judgment "describes" the members of the class, but need not specify the individual members; in a (b)(3) action the judgment "specifies" the individual members who have been identified and described the others.

Compare subdivision (c)(4) as to actions conducted as class actions only with respect to particular issues. Where the class-action character of the lawsuit is based solely on the existence of a "limited fund," the judgment, while extending to all claims of class members against the fund, has ordinarily left unaffected the personal claims of nonappearing members against the debtor. See 3 Moore, supra, par. 23.11[4].

Hitherto, in a few actions conducted as "spurious" class actions and thus nominally designed to extend only to parties and others intervening before the determination of liability, courts have held or intimated that class members might be permitted to intervene after a decision on the merits favorable to their interests, in order to secure the benefits of the decision for themselves, although they would presumably be unaffected by an unfavorable decision. See, as to the propriety of this so-called "one-way" intervention in "spurious" actions, the conflicting views expressed in *Union Carbide & Carbon Corp. v. Nisley*, 300 F.2d 561 (10th Cir. 1961), pet. cert. dism., 371 U.S. 801 (1963); *York v. Guaranty Trust Co.*, 143 F.2d 503, 529 (2d Cir. 1944), rev'd on grounds not here relevant, 326 U.S. 99 (1945); *Pentland v. Dravo Corp.*, 152 F.2d 851, 856 (3d Cir. 1945); *Speed v. Transamerica Corp.*, 100 F.Supp. 461, 463 (D.Del.1951); *State Wholesale Grocers v. Great Atl. & Pac. Tea Co.*, 24 F.R.D. 510 (N.D.Ill.1959); *Alabama Ind. Serv. Stat. Assn. v. Shell Pet. Corp.*, 28 F.Supp. 386, 390 (N.D.Ala.1939); *Tolliver v. Cudahy Packing Co.*, 39 F.Supp. 337, 339 (E.D.Tenn.1941); Kalven & Rosenfield, supra, 8 U. of Chi.L.Rev. 684 (1941); Comment, 53 Nw.U.L.Rev. 627, 632-33 (1958); *Developments in the Law*, supra, 71 Harv.L.Rev. at 935; 2 Barron & Holtzoff, supra, § 568; but cf. *Lockwood v. Hercules Powder Co.*, 7 F.R.D. 24, 28-29 (W.D.Mo.1947); *Abram v. San Joaquin Cotton Oil Co.*, 46 F.Supp. 969, 976-77 (S.D.Calif.1942); Chafee, supra, at 280, 285; 3 Moore, supra, par. 23.12, at 3476. Under proposed subdivision (c)(3), one-way intervention is excluded; the action will have been early determined to be a class or nonclass action, and in the former case the judgment, whether or not favorable, will include the class, as above stated.

Although thus declaring that the judgment in a class action includes the class, as defined, subdivision (c)(3) does not disturb the recognized principle that the court conducting the action cannot predetermine the *res judicata* effect of the judgment; this can be tested only in a subsequent action. See Restatement, Judgments § 86, comment (h), § 116 (1942). The court, however, in framing the judgment in any suit brought as a class action, must decide what its extent or coverage shall be, and if the matter is carefully considered, questions of *res judicata* are less likely to be raised at a later time and if raised will be more satisfactorily answered. See Chafee, supra, at 294; Weinstein, supra, 9 Buffalo L.Rev. at 460.

Subdivision (c)(4). This provision recognizes that an action may be maintained as a class action as to particular issues only. For example, in a fraud or similar case the action may retain its "class" character only through the adjudication of liability to the class; the members of the class may thereafter be required to come in individually and prove the amounts of their respective claims.

Two or more classes may be represented in a single action. Where a class is found to include subclasses divergent in interest, the class may be divided correspondingly, and each subclass treated as a class.

Subdivision (d) is concerned with the fair and efficient conduct of the action and lists some types of orders which may be appropriate.

The court should consider how the proceedings are to be arranged in sequence, and what measures should be taken to simplify the proof and argument. See subdivision (d)(1). The orders resulting from this consideration, like the others referred to in subdivision (d), may be combined with a pretrial order under Rule 16, and are subject to modification as the case proceeds.

Subdivision (d)(2) sets out a non-exhaustive list of possible occasions for orders requiring notice to the class. Such notice is not a novel conception. For example, in "limited fund" cases, members of the class have been notified to present individual claims after the basic class decision. Notice has gone to members of a class so that they might express any opposition to the representation, see *United States v. American Optical Co.*, 97 F.Supp. 66 (N.D.Ill.1951), and 1950-51 CCH Trade Cases 64573-74 (par. 62869); cf. *Weeks v. Bareco Oil Co.*, 125 F.2d 84, 94 (7th Cir. 1941), and notice may encourage interventions to improve the representation of the class. Cf. *Oppenheimer v. F. J. Young & Co.*, 144 F.2d 387 (2d Cir. 1944). Notice has been used to poll members on a proposed modification of a consent decree. See record in *Sam Fox Publishing Co. v. United*

States, 366 U.S. 683 (1961).

Subdivision (d)(2) does not require notice at any stage, but rather calls attention to its availability and invokes the court's discretion. In the degree that there is cohesiveness or unity in the class and the representation is effective, the need for notice to the class will tend toward a minimum. These indicators suggest that notice under subdivision (d)(2) may be particularly useful and advisable in certain class actions maintained under subdivision (b)(3), for example, to permit members of the class to object to the representation. Indeed, under subdivision (c)(2), notice must be ordered, and is not merely discretionary, to give the members in a subdivision (b)(3) class action an opportunity to secure exclusion from the class. This mandatory notice pursuant to subdivision (c)(2), together with any discretionary notice which the court may find it advisable to give under subdivision (d)(2), is designed to fulfill requirements of due process to which the class action procedure is of course subject. See *Hansberry v. Lee*, 311 U.S. 32 (1940); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950); cf. *Dickinson v. Burnham*, 197 F.2d 973, 979 (2d Cir. 1952), and studies cited at 979 in 4; see also *All American Airways, Inc. v. Elderd*, 209 F.2d 247, 249 (2d Cir. 1954); *Gart v. Cole*, 263 F.2d 244, 248-49 (2d Cir. 1959), cert. denied, 359 U.S. 978 (1959).

Notice to members of the class, whenever employed under amended Rule 23, should be accommodated to the particular purpose but need not comply with the formalities for service of process. See Chafee, supra, at 230-31; *Brendle v. Smith*, 7 F.R.D. 119 (S.D.N.Y.1946). The fact that notice is given at one stage of the action does not mean that it must be given at subsequent stages. Notice is available fundamentally "for the protection of the members of the class or otherwise for the fair conduct of the action" and should not be used merely as a device for the undesirable solicitation of claims. See the discussion in *Cherner v. Transitron Electronic Corp.*, 201 F.Supp. 934 (D.Mass.1962); *Hormel v. United States*, 17 F.R.D. 303 (S.D.N.Y.1955).

In appropriate cases the court should notify interested government agencies of the pendency of the action or of particular steps therein.

Subdivision (d)(3) reflects the possibility of conditioning the maintenance of a class action, e.g., on the strengthening of the representation, see subdivision (c)(1) above; and recognizes that the imposition of conditions on intervenors may be required for the proper and efficient conduct of the action.

As to orders under subdivision (d)(4), see subdivision (c)(1) above.

Subdivision (e) requires approval of the court, after notice, for the dismissal or compromise of any class action.

1987 Amendment

The amendments are technical. No substantive change is intended.

1998 Amendment

Subdivision (f). This permissive interlocutory appeal provision is adopted under the power conferred by 28 U.S.C. § 1292(e). Appeal from an order granting or denying class certification is permitted in the sole discretion of the court of appeals. No other type of Rule 23 order is covered by this provision. The court of appeals is given unfettered discretion whether to permit the appeal, akin to the discretion exercised by the Supreme Court in acting on a petition for certiorari. This discretion

suggests an analogy to the provision in 28 U.S.C. § 1292(b) for permissive appeal on certification by a district court. Subdivision (f), however, departs from the § 1291(b) model in two significant ways. It does not require that the district court certify the certification ruling for appeal, although the district court often can assist the parties and court of appeals by offering advice on the desirability of appeal. And it does not include the potentially limiting requirements of § 1292(b) that the district court order "involve a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation.

The courts of appeals will develop standards for granting review that reflect the changing areas of uncertainty in class litigation. The Federal Judicial Center study supports the view that many suits with class-action allegations present familiar and almost routine issues that are no more worthy of immediate appeal than many other interlocutory rulings. Yet several concerns justify expansion of present opportunities to appeal. An order denying certification may confront the plaintiff with a situation in which the only sure path to appellate review is by proceeding to final judgment on the merits of an individual claim that, standing alone, is far smaller than the costs of litigation. An order granting certification, on the other hand, may force a defendant to settle rather than incur the costs of defending a class action and run the risk of potentially ruinous liability. These concerns can be met at low cost by establishing in the court of appeals a discretionary power to grant interlocutory review in cases that show appeal-worthy certification issues.

Permission to appeal may be granted or denied on the basis of any consideration that the court of appeals finds persuasive. Permission is most likely to be granted when the certification decision turns on a novel or unsettled question of law, or when, as a practical matter, the decision on certification is likely dispositive of the litigation.

The district court, having worked through the certification decision, often will be able to provide cogent advice on the factors that bear on the decision whether to permit appeal. This advice can be particularly valuable if the certification decision is tentative. Even as to a firm certification decision, a statement of reasons bearing on the probably benefits and costs of immediate appeal can help focus the court of appeals decision, and may persuade the disappointed party that an attempt to appeal would be fruitless.

The 10-day period for seeking permission to appeal is designed to reduce the risk that attempted appeals will disrupt continuing proceedings. It is expected that the courts of appeals will act quickly in making the preliminary determination whether to permit appeal. Permission to appeal does not stay trial court proceedings. A stay should be sought first from the trial court. If the trial court refuses a stay, its action and any explanation of its views should weigh heavily with the court of appeals.

Appellate Rule 5 has been modified to establish the procedure for petitioning for leave to appeal under subdivision (f).

2003 Amendment

Subdivision (c). Subdivision (c) is amended in several respects. The requirement that the court determine whether to certify a class "as soon as practicable after commencement of an action" is replaced by requiring determination "at an early practicable time." The notice provisions are substantially revised.

Paragraph (1). Subdivision (c)(1)(A) is changed to require that the determination whether to certify a class be made "at an early practicable time." The "as soon as practicable" exaction neither reflects prevailing practice nor captures the many valid reasons that may justify deferring the initial certification decision. See Willging, Hooper & Niemic, *Empirical Study of Class Actions in Four Federal District Courts: Final Report to the Advisory Committee on Civil Rules 26-36* (Federal Judicial Center 1996).

Time may be needed to gather information necessary to make the certification decision. Although an evaluation of the probable outcome on the merits is not properly part of the certification decision, discovery in aid of the certification decision often includes information required to identify the nature of the issues that actually will be presented at trial. In this sense it is appropriate to conduct controlled discovery into the "merits," limited to those aspects relevant to making the certification decision on an informed basis. Active judicial supervision may be required to achieve the most effective balance that expedites an informed certification determination without forcing an artificial and ultimately wasteful division between "certification discovery" and "merits discovery." A critical need is to determine how the case will be tried. An increasing number of courts require a party requesting class certification to present a "trial plan" that describes the issues likely to be presented at trial and tests whether they are susceptible of class-wide proof. See Manual For Complex Litigation Third, § 21.213, p. 44; § 30.11, p. 214; § 30.12, p. 215.

Other considerations may affect the timing of the certification decision. The party opposing the class may prefer to win dismissal or summary judgment as to the individual plaintiffs without certification and without binding the class that might have been certified. Time may be needed to explore designation of class counsel under Rule 23(g), recognizing that in many cases the need to progress toward the certification determination may require designation of interim counsel under Rule 23(g)(2)(A).

Although many circumstances may justify deferring the certification decision, active management may be necessary to ensure that the certification decision is not unjustifiably delayed.

Subdivision (c)(1)(C) reflects two amendments. The provision that a class certification "may be conditional" is deleted. A court that is not satisfied that the requirements of Rule 23 have been met should refuse certification until they have been met. The provision that permits alteration or amendment of an order granting or denying class certification is amended to set the cut-off point at final judgment rather than "the decision on the merits." This change avoids the possible ambiguity in referring to "the decision on the merits." Following a determination of liability, for example, proceedings to define the remedy may demonstrate the need to amend the class definition or subdivide the class. In this setting the final judgment concept is pragmatic. It is not the same as the concept used for appeal purposes, but it should be flexible, particularly in protracted litigation.

The authority to amend an order under Rule 23(c)(1) before final judgment does not restore the practice of "one-way intervention" that was rejected by the 1966 revision of Rule 23. A determination of liability after certification, however, may show a need to amend the class definition. Decertification may be warranted after further proceedings.

If the definition of a class certified under Rule 23(b)(3) is altered to include members who have not been afforded notice and an opportunity to request exclusion, notice--including an opportunity to request exclusion--must be directed to the new class members under Rule 23(c)(2)(B).

Paragraph (2). The first change made in Rule 23(c)(2) is to call attention to the court's authority--already established in part by Rule 23(d)(2)--to direct notice of certification to a Rule 23(b)(1) or (b)(2) class. The present rule expressly requires notice only in actions certified under Rule 23(b)(3). Members of classes certified under Rules 23(b)(1) or (b)(2) have interests that may deserve protection by notice.

The authority to direct notice to class members in a (b)(1) or (b)(2) class action should be exercised with care. For several reasons, there may be less need for notice than in a (b)(3) class action. There is no right to request exclusion from a (b)(1) or (b)(2) class. The characteristics of the class may reduce the need for formal notice. The cost of providing notice, moreover,

could easily cripple actions that do not seek damages. The court may decide not to direct notice after balancing the risk that notice costs may deter the pursuit of class relief against the benefits of notice.

When the court does direct certification notice in a (b)(1) or (b)(2) class action, the discretion and flexibility established by subdivision (c)(2)(A) extend to the method of giving notice. Notice facilitates the opportunity to participate. Notice calculated to reach a significant number of class members often will protect the interests of all. Informal methods may prove effective. A simple posting in a place visited by many class members, directing attention to a source of more detailed information, may suffice. The court should consider the costs of notice in relation to the probable reach of inexpensive methods.

If a Rule 23(b)(3) class is certified in conjunction with a (b)(2) class, the (c)(2)(B) notice requirements must be satisfied as to the (b)(3) class.

The direction that class-certification notice be couched in plain, easily understood language is a reminder of the need to work unremittingly at the difficult task of communicating with class members. It is difficult to provide information about most class actions that is both accurate and easily understood by class members who are not themselves lawyers. Factual uncertainty, legal complexity, and the complication of class-action procedure raise the barriers high. The Federal Judicial Center has created illustrative clear-notice forms that provide a helpful starting point for actions similar to those described in the forms.

Subdivision (e). Subdivision (e) is amended to strengthen the process of reviewing proposed class-action settlements. Settlement may be a desirable means of resolving a class action. But court review and approval are essential to assure adequate representation of class members who have not participated in shaping the settlement.

Paragraph (1). Subdivision (e)(1)(A) expressly recognizes the power of a class representative to settle class claims, issues, or defenses.

Rule 23(e)(1)(A) resolves the ambiguity in former Rule 23(e)'s reference to dismissal or compromise of "a class action." That language could be--and at times was--read to require court approval of settlements with putative class representatives that resolved only individual claims. See Manual for Complex Litigation Third, § 30.41. The new rule requires approval only if the claims, issues, or defenses of a certified class are resolved by a settlement, voluntary dismissal, or compromise.

Subdivision (e)(1)(B) carries forward the notice requirement of present Rule 23(e) when the settlement binds the class through claim or issue preclusion; notice is not required when the settlement binds only the individual class representatives. Notice of a settlement binding on the class is required either when the settlement follows class certification or when the decisions on certification and settlement proceed simultaneously.

Reasonable settlement notice may require individual notice in the manner required by Rule 23(c)(2)(B) for certification notice to a Rule 23(b)(3) class. Individual notice is appropriate, for example, if class members are required to take action--such as filing claims--to participate in the judgment, or if the court orders a settlement opt-out opportunity under Rule 23(e)(3).

Subdivision (e)(1)(C) confirms and mandates the already common practice of holding hearings as part of the process of approving settlement, voluntary dismissal, or compromise that would bind members of a class.

Subdivision (e)(1)(C) states the standard for approving a proposed settlement that would bind class members. The settlement must be fair, reasonable, and adequate. A helpful review of many factors that may deserve consideration is provided by *In re: Prudential Ins. Co. America Sales Practice Litigation Agent Actions*, 148 F.3d 283, 316-324 (3d Cir. 1998). Further guidance can be found in the Manual for Complex Litigation.

The court must make findings that support the conclusion that the settlement is fair, reasonable, and adequate. The findings must be set out in sufficient detail to explain to class members and the appellate court the factors that bear on applying the standard.

Settlement review also may provide an occasion to review the cogency of the initial class definition. The terms of the settlement themselves, or objections, may reveal divergent interests of class members and demonstrate the need to redefine the class or to designate subclasses. Redefinition of a class certified under Rule 23(b)(3) may require notice to new class members under Rule 23(c)(2)(B). See Rule 23(c)(1)(C).

Paragraph (2). Subdivision (e)(2) requires parties seeking approval of a settlement, voluntary dismissal, or compromise under Rule 23(e)(1) to file a statement identifying any agreement made in connection with the settlement. This provision does not change the basic requirement that the parties disclose all terms of the settlement or compromise that the court must approve under Rule 23(e)(1). It aims instead at related undertakings that, although seemingly separate, may have influenced the terms of the settlement by trading away possible advantages for the class in return for advantages for others. Doubts should be resolved in favor of identification.

Further inquiry into the agreements identified by the parties should not become the occasion for discovery by the parties or objectors. The court may direct the parties to provide to the court or other parties a summary or copy of the full terms of any agreement identified by the parties. The court also may direct the parties to provide a summary or copy of any agreement not identified by the parties that the court considers relevant to its review of a proposed settlement. In exercising discretion under this rule, the court may act in steps, calling first for a summary of any agreement that may have affected the settlement and then for a complete version if the summary does not provide an adequate basis for review. A direction to disclose a summary or copy of an agreement may raise concerns of confidentiality. Some agreements may include information that merits protection against general disclosure. And the court must provide an opportunity to claim work-product or other protections.

Paragraph (3). Subdivision (e)(3) authorizes the court to refuse to approve a settlement unless the settlement affords class members a new opportunity to request exclusion from a class certified under Rule 23(b)(3) after settlement terms are known. An agreement by the parties themselves to permit class members to elect exclusion at this point by the settlement agreement may be one factor supporting approval of the settlement. Often there is an opportunity to opt out at this point because the class is certified and settlement is reached in circumstances that lead to simultaneous notice of certification and notice of settlement. In these cases, the basic opportunity to elect exclusion applies without further complication. In some cases, particularly if settlement appears imminent at the time of certification, it may be possible to achieve equivalent protection by deferring notice and the opportunity to elect exclusion until actual settlement terms are known. This approach avoids the cost and potential confusion of providing two notices and makes the single notice more meaningful. But notice should not be delayed unduly after certification in the hope of settlement.

Rule 23(e)(3) authorizes the court to refuse to approve a settlement unless the settlement affords a new opportunity to elect exclusion in a case that settles after a certification decision if the earlier opportunity to elect exclusion provided with the certification notice has expired by the time of the settlement notice. A decision to remain in the class is likely to be more carefully considered and is better informed when settlement terms are known.

The opportunity to request exclusion from a proposed settlement is limited to members of a (b)(3) class. Exclusion may be requested only by individual class members; no class member may purport to opt out other class members by way of another class action.

The decision whether to approve a settlement that does not allow a new opportunity to elect exclusion is confided to the court's discretion. The court may make this decision before directing notice to the class under Rule 23(e)(1)(B) or after the Rule 23(e)(1)(C) hearing. Many factors may influence the court's decision. Among these are changes in the information available to class members since expiration of the first opportunity to request exclusion, and the nature of the individual class members' claims.

The terms set for permitting a new opportunity to elect exclusion from the proposed settlement of a Rule 23(b)(3) class action may address concerns of potential misuse. The court might direct, for example, that class members who elect exclusion are bound by rulings on the merits made before the settlement was proposed for approval. Still other terms or conditions may be appropriate.

Paragraph (4). Subdivision (e)(4) confirms the right of class members to object to a proposed settlement, voluntary dismissal, or compromise. The right is defined in relation to a disposition that, because it would bind the class, requires court approval under subdivision (e)(1)(C).

Subdivision (e)(4)(B) requires court approval for withdrawal of objections made under subdivision (e)(4)(A). Review follows automatically if the objections are withdrawn on terms that lead to modification of the settlement with the class. Review also is required if the objector formally withdraws the objections. If the objector simply abandons pursuit of the objection, the court may inquire into the circumstances.

Approval under paragraph (4)(B) may be given or denied with little need for further inquiry if the objection and the disposition go only to a protest that the individual treatment afforded the objector under the proposed settlement is unfair because of factors that distinguish the objector from other class members. Different considerations may apply if the objector has protested that the proposed settlement is not fair, reasonable, or adequate on grounds that apply generally to a class or subclass. Such objections, which purport to represent class-wide interests, may augment the opportunity for obstruction or delay. If such objections are surrendered on terms that do not affect the class settlement or the objector's participation in the class settlement, the court often can approve withdrawal of the objections without elaborate inquiry.

Once an objector appeals, control of the proceeding lies in the court of appeals. The court of appeals may undertake review and approval of a settlement with the objector, perhaps as part of appeal settlement procedures, or may remand to the district court to take advantage of the district court's familiarity with the action and settlement.

Subdivision (g). Subdivision (g) is new. It responds to the reality that the selection and activity of class counsel are often critically important to the successful handling of a class action. Until now, courts have scrutinized proposed class counsel as well as the class representative under Rule 23(a)(4). This experience has recognized the importance of judicial evaluation of the proposed lawyer for the class, and this new subdivision builds on that experience rather than introducing an entirely new element into the class certification process. Rule 23(a)(4) will continue to call for scrutiny of the proposed class representative, while this subdivision will guide the court in assessing proposed class counsel as part of the certification decision. This subdivision recognizes the importance of class counsel, states the obligation to represent the interests of the class, and provides a framework for selection of class counsel. The procedure and standards for appointment vary depending on whether there are multiple applicants to be class counsel. The new subdivision also provides a method by which the court may make directions from the outset about the potential fee award to class counsel in the event the action is successful.

Paragraph (1) sets out the basic requirement that class counsel be appointed if a class is certified and articulates the obligation of class counsel to represent the interests of the class, as opposed to the potentially conflicting interests of individual class members. It also sets out the factors the court should consider in assessing proposed class counsel.

Paragraph (1)(A) requires that the court appoint class counsel to represent the class. Class counsel must be appointed for all classes, including each subclass that the court certifies to represent divergent interests.

Paragraph (1)(A) does not apply if "a statute provides otherwise." This recognizes that provisions of the Private Securities Litigation Reform Act of 1995, Pub. L. No. 104-67, 109 Stat. 737 (1995) (codified in various sections of 15 U.S.C.), contain directives that bear on selection of a lead plaintiff and the retention of counsel. This subdivision does not purport to supersede or to affect the interpretation of those provisions, or any similar provisions of other legislation.

Paragraph 1(B) recognizes that the primary responsibility of class counsel, resulting from appointment as class counsel, is to represent the best interests of the class. The rule thus establishes the obligation of class counsel, an obligation that may be different from the customary obligations of counsel to individual clients. Appointment as class counsel means that the primary obligation of counsel is to the class rather than to any individual members of it. The class representatives do not have an unfettered right to "fire" class counsel. In the same vein, the class representatives cannot command class counsel to accept or reject a settlement proposal. To the contrary, class counsel must determine whether seeking the court's approval of a settlement would be in the best interests of the class as a whole.

Paragraph (1)(C) articulates the basic responsibility of the court to appoint class counsel who will provide the adequate representation called for by paragraph (1)(B). It identifies criteria that must be considered and invites the court to consider any other pertinent matters. Although couched in terms of the court's duty, the listing also informs counsel seeking appointment about the topics that should be addressed in an application for appointment or in the motion for class certification.

The court may direct potential class counsel to provide additional information about the topics mentioned in paragraph (1)(C) or about any other relevant topic. For example, the court may direct applicants to inform the court concerning any agreements about a prospective award of attorney fees or nontaxable costs, as such agreements may sometimes be significant in the selection of class counsel. The court might also direct that potential class counsel indicate how parallel litigation might be coordinated or consolidated with the action before the court.

The court may also direct counsel to propose terms for a potential award of attorney fees and nontaxable costs. Attorney fee awards are an important feature of class action practice, and attention to this subject from the outset may often be a productive technique. Paragraph (2)(C) therefore authorizes the court to provide directions about attorney fees and costs when appointing class counsel. Because there will be numerous class actions in which this information is not likely to be useful, the court need not consider it in all class actions.

Some information relevant to class counsel appointment may involve matters that include adversary preparation in a way that should be shielded from disclosure to other parties. An appropriate protective order may be necessary to preserve confidentiality.

In evaluating prospective class counsel, the court should weigh all pertinent factors. No single factor should necessarily be determinative in a given case. For example, the resources counsel will commit to the case must be appropriate to its needs, but the court should be careful not to limit consideration to lawyers with the greatest resources.

If, after review of all applicants, the court concludes that none would be satisfactory class counsel, it may deny class certification, reject all applications, recommend that an application be modified, invite new applications, or make any other appropriate order regarding selection and appointment of class counsel.

Paragraph (2). This paragraph sets out the procedure that should be followed in appointing class counsel. Although it affords substantial flexibility, it provides the framework for appointment of class counsel in all class actions. For counsel who filed the action, the materials submitted in support of the motion for class certification may suffice to justify appointment so long as the information described in paragraph (g)(1)(C) is included. If there are other applicants, they ordinarily would file a formal application detailing their suitability for the position.

In a plaintiff class action the court usually would appoint as class counsel only an attorney or attorneys who have sought appointment. Different considerations may apply in defendant class actions.

The rule states that the court should appoint "class counsel." In many instances, the applicant will be an individual attorney. In other cases, however, an entire firm, or perhaps numerous attorneys who are not otherwise affiliated but are collaborating on the action will apply. No rule of thumb exists to determine when such arrangements are appropriate; the court should be alert to the need for adequate staffing of the case, but also to the risk of overstaffing or an ungainly counsel structure.

Paragraph (2)(A) authorizes the court to designate interim counsel during the pre-certification period if necessary to protect the interests of the putative class. Rule 23(c)(1)(B) directs that the order certifying the class include appointment of class counsel. Before class certification, however, it will usually be important for an attorney to take action to prepare for the certification decision. The amendment to Rule 23(c)(1) recognizes that some discovery is often necessary for that determination. It also may be important to make or respond to motions before certification. Settlement may be discussed before certification. Ordinarily, such work is handled by the lawyer who filed the action. In some cases, however, there may be rivalry or uncertainty that makes formal designation of interim counsel appropriate. Rule 23(g)(2)(A) authorizes the court to designate interim counsel to act on behalf of the putative class before the certification decision is made. Failure to make the formal designation does not prevent the attorney who filed the action from proceeding in it. Whether or not formally designated interim counsel, an attorney who acts on behalf of the class before certification must act in the best interests of the class as a whole. For example, an attorney who negotiates a pre-certification settlement must seek a settlement that is fair, reasonable, and adequate for the class.

Rule 23(c)(1) provides that the court should decide whether to certify the class "at an early practicable time," and directs that class counsel should be appointed in the order certifying the class. In some cases, it may be appropriate for the court to allow a reasonable period after commencement of the action for filing applications to serve as class counsel. The primary ground for deferring appointment would be that there is reason to anticipate competing applications to serve as class counsel. Examples might include instances in which more than one class action has been filed, or in which other attorneys have filed individual actions on behalf of putative class members. The purpose of facilitating competing applications in such a case is to afford the best possible representation for the class. Another possible reason for deferring appointment would be that the initial applicant was found inadequate, but it seems appropriate to permit additional applications rather than deny class certification.

Paragraph (2)(B) states the basic standard the court should use in deciding whether to certify the class and appoint class counsel in the single applicant situation--that the applicant be able to provide the representation called for by paragraph (1)(B) in light of the factors identified in paragraph (1)(C).

If there are multiple adequate applicants, paragraph (2)(B) directs the court to select the class counsel best able to represent the interests of the class. This decision should also be made using the factors outlined in paragraph (1)(C), but in the multiple applicant situation the court is to go beyond scrutinizing the adequacy of counsel and make a comparison of the strengths of the various applicants. As with the decision whether to appoint the sole applicant for the position, no single factor should be dispositive in selecting class counsel in cases in which there are multiple applicants. The fact that a given attorney filed the instant action, for example, might not weigh heavily in the decision if that lawyer had not done significant work identifying or investigating claims. Depending on the nature of the case, one important consideration might be the applicant's existing attorney-client relationship with the proposed class representative.

Paragraph (2)(C) builds on the appointment process by authorizing the court to include provisions regarding attorney fees in the order appointing class counsel. Courts may find it desirable to adopt guidelines for fees or nontaxable costs, or to direct class counsel to report to the court at regular intervals on the efforts undertaken in the action, to facilitate the court's later determination of a reasonable attorney fee.

Subdivision (h). Subdivision (h) is new. Fee awards are a powerful influence on the way attorneys initiate, develop, and conclude class actions. Class action attorney fee awards have heretofore been handled, along with all other attorney fee awards, under Rule 54(d)(2), but that rule is not addressed to the particular concerns of class actions. This subdivision is designed to work in tandem with new subdivision (g) on appointment of class counsel, which may afford an opportunity for the court to provide an early framework for an eventual fee award, or for monitoring the work of class counsel during the pendency of the action.

Subdivision (h) applies to "an action certified as a class action." This includes cases in which there is a simultaneous proposal for class certification and settlement even though technically the class may not be certified unless the court approves the settlement pursuant to review under Rule 23(e). When a settlement is proposed for Rule 23(e) approval, either after certification or with a request for certification, notice to class members about class counsel's fee motion would ordinarily accompany the notice to the class about the settlement proposal itself.

This subdivision does not undertake to create new grounds for an award of attorney fees or nontaxable costs. Instead, it applies when such awards are authorized by law or by agreement of the parties. Against that background, it provides a format for all awards of attorney fees and nontaxable costs in connection with a class action, not only the award to class counsel. In some situations, there may be a basis for making an award to other counsel whose work produced a beneficial result for the class, such as attorneys who acted for the class before certification but were not appointed class counsel, or attorneys who represented objectors to a proposed settlement under Rule 23(e) or to the fee motion of class counsel. Other situations in which fee awards are authorized by law or by agreement of the parties may exist.

This subdivision authorizes an award of "reasonable" attorney fees and nontaxable costs. This is the customary term for measurement of fee awards in cases in which counsel may obtain an award of fees under the "common fund" theory that applies in many class actions, and is used in many fee-shifting statutes. Depending on the circumstances, courts have approached the determination of what is reasonable in different ways. In particular, there is some variation among courts about whether in "common fund" cases the court should use the lodestar or a percentage method of determining what fee is reasonable. The rule does not attempt to resolve the question whether the lodestar or percentage approach should be viewed as preferable.

Active judicial involvement in measuring fee awards is singularly important to the proper operation of the class-action process. Continued reliance on caselaw development of fee-award measures does not diminish the court's responsibility. In a class action, the district court must ensure that the amount and mode of payment of attorney fees are fair and proper whether the fees come from a common fund or are otherwise paid. Even in the absence of objections, the court bears this responsibility.

Courts discharging this responsibility have looked to a variety of factors. One fundamental focus is the result actually achieved for class members, a basic consideration in any case in which fees are sought on the basis of a benefit achieved for class members. The Private Securities Litigation Reform Act of 1995 explicitly makes this factor a cap for a fee award in actions to which it applies. See 15 U.S.C. §§ 77z-1(a)(6); 78u-4(a)(6) (fee award should not exceed a "reasonable percentage of the amount of any damages and prejudgment interest actually paid to the class"). For a percentage approach to fee measurement, results achieved is the basic starting point.

In many instances, the court may need to proceed with care in assessing the value conferred on class members. Settlement regimes that provide for future payments, for example, may not result in significant actual payments to class members. In this connection, the court may need to scrutinize the manner and operation of any applicable claims procedure. In some cases, it may be appropriate to defer some portion of the fee award until actual payouts to class members are known. Settlements involving nonmonetary provisions for class members also deserve careful scrutiny to ensure that these provisions have actual value to the class. On occasion the court's Rule 23(e) review will provide a solid basis for this sort of evaluation, but in any event it is also important to assessing the fee award for the class.

At the same time, it is important to recognize that in some class actions the monetary relief obtained is not the sole determinant of an appropriate attorney fees award. Cf. *Blanchard v. Bergeron*, 489 U.S. 87, 95 (1989) (cautioning in an individual case against an "undesirable emphasis" on "the importance of the recovery of damages in civil rights litigation" that might "shortchange efforts to seek effective injunctive or declaratory relief").

Any directions or orders made by the court in connection with appointing class counsel under Rule 23(g) should weigh heavily in making a fee award under this subdivision.

Courts have also given weight to agreements among the parties regarding the fee motion, and to agreements between class counsel and others about the fees claimed by the motion. Rule 54(d)(2)(B) provides: "If directed by the court, the motion shall also disclose the terms of any agreement with respect to fees to be paid for the services for which claim is made." The agreement by a settling party not to oppose a fee application up to a certain amount, for example, is worthy of consideration, but the court remains responsible to determine a reasonable fee. "Side agreements" regarding fees provide at least perspective pertinent to an appropriate fee award.

In addition, courts may take account of the fees charged by class counsel or other attorneys for representing individual claimants or objectors in the case. In determining a fee for class counsel, the court's objective is to ensure an overall fee that is fair for counsel and equitable within the class. In some circumstances individual fee agreements between class counsel and class members might have provisions inconsistent with those goals, and the court might determine that adjustments in the class fee award were necessary as a result.

Finally, it is important to scrutinize separately the application for an award covering nontaxable costs. If costs were addressed in the order appointing class counsel, those directives should be a presumptive starting point in determining what is an appropriate award.

Paragraph (1). Any claim for an award of attorney fees must be sought by motion under Rule 54(d)(2), which invokes the provisions for timing of appeal in Rule 58 and Appellate Rule 4. Owing to the distinctive features of class action fee motions, however, the provisions of this subdivision control disposition of fee motions in class actions, while Rule 54(d)(2) applies to matters not addressed in this subdivision.

The court should direct when the fee motion must be filed. For motions by class counsel in cases subject to court review of a proposed settlement under Rule 23(e), it would be important to require the filing of at least the initial motion in time for inclusion of information about the motion in the notice to the class about the proposed settlement that is required by Rule 23(e). In cases litigated to judgment, the court might also order class counsel's motion to be filed promptly so that notice to the class under this subdivision (h) can be given.

Besides service of the motion on all parties, notice of class counsel's motion for attorney fees must be "directed to the class in a reasonable manner." Because members of the class have an interest in the arrangements for payment of class counsel whether that payment comes from the class fund or is made directly by another party, notice is required in all instances. In cases in which settlement approval is contemplated under Rule 23(e), notice of class counsel's fee motion should be combined with notice of the proposed settlement, and the provision regarding notice to the class is parallel to the requirements for notice under Rule 23(e). In adjudicated class actions, the court may calibrate the notice to avoid undue expense.

Paragraph (2). A class member and any party from whom payment is sought may object to the fee motion. Other parties--for example, nonsettling defendants--may not object because they lack a sufficient interest in the amount the court awards. The rule does not specify a time limit for making an objection. In setting the date objections are due, the court should provide sufficient time after the full fee motion is on file to enable potential objectors to examine the motion.

The court may allow an objector discovery relevant to the objections. In determining whether to allow discovery, the court should weigh the need for the information against the cost and delay that would attend discovery. See Rule 26(b)(2). One factor in determining whether to authorize discovery is the completeness of the material submitted in support of the fee motion, which depends in part on the fee measurement standard applicable to the case. If the motion provides thorough information, the burden should be on the objector to justify discovery to obtain further information.

Paragraph (3). Whether or not there are formal objections, the court must determine whether a fee award is justified and, if so, set a reasonable fee. The rule does not require a formal hearing in all cases. The form and extent of a hearing depend on the circumstances of the case. The rule does require findings and conclusions under Rule 52(a).

Paragraph (4). By incorporating Rule 54(d)(2), this provision gives the court broad authority to obtain assistance in determining the appropriate amount to award. In deciding whether to direct submission of such questions to a special master or magistrate judge, the court should give appropriate consideration to the cost and delay that such a process might entail.

2007 Amendment

The language of Rule 23 has been amended as part of the general restyling of the Civil Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only.

Amended Rule 23(d)(2) carries forward the provisions of former Rule 23(d) that recognize two separate propositions. First, a Rule 23(d) order may be combined with a pretrial order under Rule 16. Second, the standard for amending the Rule 23(d) order continues to be the more open-ended standard for amending Rule 23(d) orders, not the more exacting standard for amending Rule 16 orders.

As part of the general restyling, intensifiers that provide emphasis but add no meaning are consistently deleted. Amended Rule 23(f) omits as redundant the explicit reference to court of appeals discretion in deciding whether to permit an interlocutory appeal. The omission does not in any way limit the unfettered discretion established by the original rule.

2009 Amendment

The time set in the former rule at 10 days has been revised to 14 days. See the Note to Rule 6.

Notes of Decisions (420)

Fed. Rules Civ. Proc. Rule 23, 28 U.S.C.A., FRCP Rule 23
Including Amendments Received Through 4-1-18

End of Document

United States Code Annotated
Federal Rules of Civil Procedure for the United States District Courts (Refs & Annos)
Title VIII. Provisional and Final Remedies (Refs & Annos)

Federal Rules of Civil Procedure Rule 65

Rule 65. Injunctions and Restraining Orders

Currentness

(a) Preliminary Injunction.

(1) ***Notice.*** The court may issue a preliminary injunction only on notice to the adverse party.

(2) ***Consolidating the Hearing with the Trial on the Merits.*** Before or after beginning the hearing on a motion for a preliminary injunction, the court may advance the trial on the merits and consolidate it with the hearing. Even when consolidation is not ordered, evidence that is received on the motion and that would be admissible at trial becomes part of the trial record and need not be repeated at trial. But the court must preserve any party's right to a jury trial.

(b) Temporary Restraining Order.

(1) ***Issuing Without Notice.*** The court may issue a temporary restraining order without written or oral notice to the adverse party or its attorney only if:

(A) specific facts in an affidavit or a verified complaint clearly show that immediate and irreparable injury, loss, or damage will result to the movant before the adverse party can be heard in opposition; and

(B) the movant's attorney certifies in writing any efforts made to give notice and the reasons why it should not be required.

(2) ***Contents; Expiration.*** Every temporary restraining order issued without notice must state the date and hour it was issued; describe the injury and state why it is irreparable; state why the order was issued without notice; and be promptly filed in the clerk's office and entered in the record. The order expires at the time after entry--not to exceed 14 days--that the court sets, unless before that time the court, for good cause, extends it for a like period or the adverse party consents to a longer extension. The reasons for an extension must be entered in the record.

(3) ***Expediting the Preliminary-Injunction Hearing.*** If the order is issued without notice, the motion for a preliminary injunction must be set for hearing at the earliest possible time, taking precedence over all other matters except hearings on older matters of the same character. At the hearing, the party who obtained the order must proceed with the motion; if the party does not, the court must dissolve the order.

(4) ***Motion to Dissolve.*** On 2 days' notice to the party who obtained the order without notice--or on shorter notice set by the court--the adverse party may appear and move to dissolve or modify the order. The court must then hear and decide the motion as promptly as justice requires.

(c) Security. The court may issue a preliminary injunction or a temporary restraining order only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained. The United States, its officers, and its agencies are not required to give security.

(d) Contents and Scope of Every Injunction and Restraining Order.

(1) ***Contents.*** Every order granting an injunction and every restraining order must:

(A) state the reasons why it issued;

(B) state its terms specifically; and

(C) describe in reasonable detail--and not by referring to the complaint or other document--the act or acts restrained or required.

(2) ***Persons Bound.*** The order binds only the following who receive actual notice of it by personal service or otherwise:

(A) the parties;

(B)the parties' officers, agents, servants, employees, and attorneys; and

(C) other persons who are in active concert or participation with anyone described in Rule 65(d)(2)(A) or (B).

(e) Other Laws Not Modified. These rules do not modify the following:

(1) any federal statute relating to temporary restraining orders or preliminary injunctions in actions affecting employer and employee;

(2) 28 U.S.C. § 2361, which relates to preliminary injunctions in actions of interpleader or in the nature of interpleader; or

(3) 28 U.S.C. § 2284, which relates to actions that must be heard and decided by a three-judge district court.

(f) Copyright Impoundment. This rule applies to copyright-impoundment proceedings.

CREDIT(S)

(Amended December 27, 1946, effective March 19, 1948; December 29, 1948, effective October 20, 1949; February 28, 1966, effective July 1, 1966; March 2, 1987, effective August 1, 1987; April 23, 2001, effective December 1, 2001; April 30, 2007, effective December 1, 2007; March 26, 2009, effective December 1, 2009.)

ADVISORY COMMITTEE NOTES

1937 Adoption

Note to Subdivisions (a) and (b). These are taken from U.S.C., Title 28, [former] § 381 (Injunctions; preliminary injunctions and temporary restraining orders).

Note to Subdivision (c). Except for the last sentence, this is substantially U.S.C., Title 28, [former] § 382 (Injunctions; security on issuance of). The last sentence continues the following and similar statutes which expressly except the United States or an officer or agency thereof from such security requirements: U.S.C. Title 15, §§ 77t(b), 78u(e), and 79r(f) (Securities and Exchange Commission). It also excepts the United States or an officer or agency thereof from such security requirements in any action in which a restraining order or interlocutory judgment of injunction issues in its favor whether there is an express statutory exception from such security requirements or not.

See U.S.C., [former] Title 6 (Official and Penal Bonds) for bonds by surety companies.

Note to Subdivision (d). This is substantially U.S.C., Title 28, [former] § 383 (Injunctions; requisites of order; binding effect).

Note to Subdivision (e). The words “relating to temporary restraining orders and preliminary injunctions in actions affecting

employer and employee" are words of description and not of limitation.

Compare [former] Equity Rule 73 (Preliminary Injunctions and Temporary Restraining Orders) which is substantially equivalent to the statutes.

For other statutes dealing with injunctions which are continued, see e.g.:

U.S.C., Title 28 former:

§ 46 [now 2324] (Suits to enjoin orders of Interstate Commerce Commission to be against United States)

§ 47 [now 2325] (Injunctions as to orders of Interstate Commerce Commission; appeal to Supreme Court; time for taking)

§ 378 [former] (Injunctions; when granted)

§ 379 [now 2283] (Injunctions; stay in State courts)

§ 380 [now 1253, 2101, 2281, 2284] (Injunctions; alleged unconstitutionality of State statutes; appeal to Supreme Court)

§ 380a [now 1253, 2101, 2281, 2284] (Injunctions; constitutionality of Federal statute; application for hearing; appeal to Supreme Court)

U.S.C., Title 7:

§ 216 (Court proceedings to enforce orders; injunction)

§ 217 (Proceedings for suspension of orders)

U.S.C., Title 15:

§ 4 (Jurisdiction of courts; duty of district attorney; procedure)

§ 25 (Restraining violations; procedure)

§ 26 (Injunctive relief for private parties; exceptions)

§ 77t(b) (Injunctions and prosecution of offenses)

1946 Amendment

Note. It has been held that in actions on preliminary injunction bonds the district court has discretion to grant relief in the same proceeding or to require the institution of a new action on the bond. *Russell v. Farley*, 1881, 105 U.S. 433, 466. It is believed, however, that in all cases the litigant should have a right to proceed on the bond in the same proceeding, in the manner provided in Rule 73(f) for a similar situation. The paragraph added to Rule 65(c) insures this result and is in the interest of efficiency. There is no reason why Rules 65(c) and 73(f) should operate differently. Compare § 50, sub. n of the Bankruptcy Act, 11 U.S.C. § 78, sub. n, under which actions on all bonds furnished pursuant to the Act may be proceeded upon summarily in the bankruptcy court. See 2 *Collier on Bankruptcy*, 14th ed. by Moore and Oglebay, 1853-1854.

1948 Amendment

The amendment effective October 1949, changed subdivision (e) in the following respects: in the first clause the amendment substituted the words "any statute of the United States" for the words "the Act of October 15, 1914, c. 323, §§ 1 and 20 (38 Stat. 730), U.S.C., Title 29, §§ 52 and 53, or the Act of March 23, 1932, c. 90 (47 Stat. 70), U.S.C., Title 29, c. 6"; in the second clause of subdivision (e) the amendment substituted the reference to "Title 28, U.S.C., § 2361" for the reference to "Section 24(26) of the Judicial Code as amended, U.S.C., Title 28, § 41(26)"; and the third clause was amended to read "Title 28, U.S.C., § 2284," etc., as at present, instead of "the Act of August 24, 1937, c. 754, § 3, relating to actions to enjoin the enforcement of acts of Congress."

1966 Amendment

Subdivision (a)(2). This new subdivision provides express authority for consolidating the hearing of an application for a preliminary injunction with the trial on the merits. The authority can be exercised with particular profit when it appears that a substantial part of the evidence offered on the application will be relevant to the merits and will be presented in such form as to qualify for admission on the trial proper. Repetition of evidence is thereby avoided. The fact that the proceedings have been consolidated should cause no delay in the disposition of the application for the preliminary injunction, for the evidence will be directed in the first instance to that relief, and the preliminary injunction, if justified by the proof, may be issued in the course of the consolidated proceedings. Furthermore, to consolidate the proceedings will tend to expedite the final disposition of the action. It is believed that consolidation can be usefully availed of in many cases.

The subdivision further provides that even when consolidation is not ordered, evidence received in connection with an application for a preliminary injunction which would be admissible on the trial on the merits forms part of the trial record. This evidence need not be repeated on the trial. On the other hand, repetition is not altogether prohibited. That would be impractical and unwise. For example, a witness testifying comprehensively on the trial who has previously testified upon the application for a preliminary injunction might sometimes be hamstrung in telling his story if he could not go over some part of his prior testimony to connect it with his present testimony. So also, some repetition of testimony may be called for where the trial is conducted by a judge who did not hear the application for the preliminary injunction. In general, however, repetition can be avoided with an increase of efficiency in the conduct of the case and without any distortion of the presentation of evidence by the parties.

Since an application for a preliminary injunction may be made in an action in which, with respect to all or part of the merits, there is a right to trial by jury, it is appropriate to add the caution appearing in the last sentence of the subdivision. In such a case the jury will have to hear all the evidence bearing on its verdict, even if some part of the evidence has already been heard

by the judge alone on the application for the preliminary injunction.

The subdivision is believed to reflect the substance of the best current practice and introduces no novel conception.

Subdivision (b). In view of the possibly drastic consequences of a temporary restraining order, the opposition should be heard, if feasible, before the order is granted. Many judges have properly insisted that, when time does not permit of formal notice of the application to the adverse party, some expedient, such as telephonic notice to the attorney for the adverse party, be resorted to if this can reasonably be done. On occasion, however, temporary restraining orders have been issued without any notice when it was feasible for some fair, although informal, notice to be given. See the emphatic criticisms in *Pennsylvania Rd. Co. v. Transport Workers Union*, 278 F.2d 693, 694 (3d Cir. 1960); *Arvida Corp. v. Sugarman*, 259 F.2d 428, 429 (2d Cir. 1958); *Lummus Co. v. Commonwealth Oil Ref. Co., Inc.*, 297 F.2d 80, 83 (2d Cir. 1961), cert. denied, 368 U.S. 986 (1962).

Heretofore the first sentence of subdivision (b), in referring to a notice "served" on the "adverse party" on which a "hearing" could be held, perhaps invited the interpretation that the order might be granted without notice if the circumstances did not permit of a formal hearing on the basis of a formal notice. The subdivision is amended to make it plain that informal notice, which may be communicated to the attorney rather than the adverse party, is to be preferred to no notice at all.

Before notice can be dispensed with, the applicant's counsel must give his certificate as to any efforts made to give notice and the reasons why notice should not be required. This certificate is in addition to the requirement of an affidavit or verified complaint setting forth the facts as to the irreparable injury which would result before the opposition could be heard.

The amended subdivision continues to recognize that a temporary restraining order may be issued without any notice when the circumstances warrant.

Subdivision (c). Original Rules 65 and 73 contained substantially identical provisions for summary proceedings against sureties on bonds required or permitted by the rules. There was fragmentary coverage of the same subject in the Admiralty Rules. Clearly, a single comprehensive rule is required, and is incorporated as Rule 65.1.

1987 Amendment

The amendments are technical. No substantive change is intended.

2001 Amendment

New subdivision (f) is added in conjunction with abrogation of the antiquated Copyright Rules of Practice adopted for proceedings under the 1909 Copyright Act. Courts have naturally turned to Rule 65 in response to the apparent inconsistency of the former Copyright Rules with the discretionary impoundment procedure adopted in 1976, 17 U.S.C. § 503(a). Rule 65 procedures also have assuaged well-founded doubts whether the Copyright Rules satisfy more contemporary requirements of due process. See, e.g., *Religious Technology Center v. Netcom On-Line Communications Servs., Inc.*, 923 F.Supp. 1231, 1260-1265 (N.D.Cal.1995); *Paramount Pictures Corp. v. Doe*, 821 F.Supp. 82 (E.D.N.Y.1993); *WPOW, Inc. v. MRLJ Enterprises*, 584 F.Supp. 132 (D.D.C.1984).

A common question has arisen from the experience that notice of a proposed impoundment may enable an infringer to defeat the court's capacity to grant effective relief. Impoundment may be ordered on an ex parte basis under subdivision (b) if the applicant makes a strong showing of the reasons why notice is likely to defeat effective relief. Such no-notice procedures are authorized in trademark infringement proceedings, see 15 U.S.C. § 1116(d), and courts have provided clear illustrations of the kinds of showings that support ex parte relief. See *Matter of Vuitton et Fils S.A.*, 606 F.2d 1 (2d Cir.1979); *Vuitton v. White*, 945 F.2d 569 (3d Cir.1991). In applying the tests for no-notice relief, the court should ask whether impoundment is necessary, or whether adequate protection can be had by a less intrusive form of no-notice relief shaped as a temporary restraining order.

This new subdivision (f) does not limit use of trademark procedures in cases that combine trademark and copyright claims. Some observers believe that trademark procedures should be adopted for all copyright cases, a proposal better considered by Congressional processes than by rulemaking processes.

2007 Amendment

The language of Rule 65 has been amended as part of the general restyling of the Civil Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only.

The final sentence of former Rule 65(c) referred to Rule 65.1. It is deleted as unnecessary. Rule 65.1 governs of its own force.

Rule 65(d)(2) clarifies two ambiguities in former Rule 65(d). The former rule was adapted from former 28 U.S.C. § 363, but omitted a comma that made clear the common doctrine that a party must have actual notice of an injunction in order to be bound by it. Amended Rule 65(d) restores the meaning of the earlier statute, and also makes clear the proposition that an injunction can be enforced against a person who acts in concert with a party's officer, agent, servant, employee, or attorney.

2009 Amendment

The time set in the former rule at 10 days has been revised to 14 days. See the Note to Rule 6.

Notes of Decisions (6120)

Fed. Rules Civ. Proc. Rule 65, 28 U.S.C.A., FRCP Rule 65
Including Amendments Received Through 4-1-18

End of Document

United States Code Annotated
Federal Rules of Civil Procedure for the United States District Courts (Refs & Annos)
Title XI. General Provisions

Federal Rules of Civil Procedure Rule 82

Rule 82. Jurisdiction and Venue Unaffected

Currentness

These rules do not extend or limit the jurisdiction of the district courts or the venue of actions in those courts. An admiralty or maritime claim under Rule 9(h) is governed by 28 U.S.C. § 1390.

CREDIT(S)

(Amended December 29, 1948, effective October 20, 1949; February 28, 1966, effective July 1, 1966; April 23, 2001, effective December 1, 2001; April 30, 2007, effective December 1, 2007; April 28, 2016, effective December 1, 2016.)

Fed. Rules Civ. Proc. Rule 82, 28 U.S.C.A., FRCP Rule 82
Including Amendments Received Through 4-1-18

End of Document

Code of Federal Regulations
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter C. Medical Assistance Programs
Part 435. Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa (Refs & Annos)
Subpart J. Eligibility in the States and District of Columbia (Refs & Annos)
Furnishing Medicaid

42 C.F.R. § 435.930

§ 435.930 Furnishing Medicaid.

Effective: July 16, 2012

Currentness

The agency must—

(a) Furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures;

(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

(c) Make arrangements to assist applicants and beneficiaries to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

SOURCE: 43 FR 45204, Sept. 29, 1978; 44 FR 17937, March 23, 1979; 51 FR 41338, 41350, Nov. 14, 1986; 77 FR 17203, March 23, 2012; 77 FR 29028, May 16, 2012, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Notes of Decisions (50)

Current through April 26, 2018; 83 FR 18236.

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