

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(3) Working with health insurance counseling programs

To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 1395b-4 of this title) to facilitate the provision of information to individuals entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.

(Aug. 14, 1935, ch. 531, title XVIII, § 1808, as added and amended Pub. L. 108-173, title IX, §§ 900(a), (b), 923(a), Dec. 8, 2003, 117 Stat. 2369, 2393.)

AMENDMENTS

2003—Subsec. (b). Pub. L. 108-173, § 900(b), added subsec. (b).

Subsec. (c). Pub. L. 108-173, § 923(a), added subsec. (c).

DEADLINE FOR APPOINTMENT

Pub. L. 108-173, title IX, § 923(b), Dec. 8, 2003, 117 Stat. 2394, provided that: “By not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall appoint the Medicare Beneficiary Ombudsman under section 1808(c) of the Social Security Act [42 U.S.C. 1395b-9(c)], as added by subsection (a).”

§ 1395b-10. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, and gender. In conducting such evaluation, the Secretary shall consider the following objectives:

- (1) Protecting patient privacy.
- (2) Minimizing the administrative burdens of data collection and reporting on providers and health plans participating under this subchapter.
- (3) Improving Medicare program data on race, ethnicity, and gender.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after July 15, 2008, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, and gender for the original Medicare fee-for-service program under parts A and B, the Medicare Advantage program under part C, and the Medicare prescription drug program under part D; and

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w-22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on the basis of race, ethnicity, and gender.

(2) Reports on data analyses

Not later than 4 years after July 15, 2008, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for Medicare beneficiaries based on analyses of the data collected under subsection (c).

(c) Implementing effective approaches

Not later than 24 months after July 15, 2008, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, and gender.

(Aug. 14, 1935, ch. 531, title XVIII, § 1809, as added Pub. L. 110-275, title I, § 185, July 15, 2008, 122 Stat. 2587.)

PART A—HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED

§ 1395c. Description of program

The insurance program for which entitlement is established by sections 426 and 426-1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

(Aug. 14, 1935, ch. 531, title XVIII, § 1811, as added Pub. L. 89-97, title I, § 102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 92-603, title II, § 201(a)(2), Oct. 30, 1972, 86 Stat. 1371; Pub. L. 95-292, § 4(a), June 13, 1978, 92 Stat. 635; Pub. L. 96-265, title I, § 103(a)(2), June 9, 1980, 94 Stat. 444; Pub. L. 96-473, § 2(b), Oct. 19, 1980, 94 Stat. 2263; Pub. L. 96-499, title IX, § 930(a), Dec. 5, 1980, 94 Stat. 2631; Pub. L. 97-248, title I, § 122(a)(1), title II, § 278(b)(3), Sept. 3, 1982, 96 Stat. 356, 561; Pub. L. 99-272, title XIII, § 13205(b)(2)(C)(i), Apr. 7, 1986, 100 Stat. 317; Pub. L. 100-360, title I, § 104(d)(1), July 1, 1988, 102 Stat. 688; Pub. L. 101-234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979.)

AMENDMENTS

1989—Pub. L. 101-234 repealed Pub. L. 100-360, §104(d)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Pub. L. 100-360 substituted “inpatient hospital services, extended care services” for “hospital, related post-hospital”.

1986—Pub. L. 99-272 substituted “government employment” for “Federal employment” in cls. (1) and (2).

1982—Pub. L. 97-248, §122(a)(1), substituted “home health services, and hospice care” for “and home health services”.

Pub. L. 97-248, §278(b)(3), inserted “(or would be eligible for such benefits if certain Federal employment were covered employment under such subchapter)” after “subchapter II of this chapter” in cl. (1), and inserted “(or would have been so entitled to such benefits if certain Federal employment were covered employment under such subchapter)” after “subchapter II of this chapter” in cl. (2).

1980—Pub. L. 96-499 substituted “, related post-hospital, and home health services” for “and related post-hospital services”.

Pub. L. 96-473 substituted “are eligible for” for “are entitled to”.

Pub. L. 96-265 substituted “not less than 24 months” for “not less than 24 consecutive months”.

1978—Pub. L. 95-292 inserted references to section 426-1 of this title and to individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

1972—Pub. L. 92-603 designated existing provisions as cl. (1) and added cl. (2).

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-234, title I, §101(d), Dec. 13, 1989, 103 Stat. 1980, provided that: “The provisions of this section [amending this section and sections 1395d, 1395e, 1395f, 1395k, 1395x, 1395cc, and 1395tt of this title, enacting provisions set out as notes under sections 1395e and 1395ww of this title, and amending provisions set out as notes under sections 1395e and 1395ww of this title] shall take effect January 1, 1990, except that the amendments made by subsection (c) [amending provisions set out as a note under section 1395ww of this title] shall be effective as if included in the enactment of MCCA [Pub. L. 100-360].”

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100-360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100-360, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99-272 effective after Mar. 31, 1986, with no individual to be considered under disability for any period beginning before Apr. 1, 1986, for purposes of hospital insurance benefits, see section 13205(d)(2) of Pub. L. 99-272, set out as a note under section 410 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97-248, title I, §122(h)(1), Sept. 3, 1982, 96 Stat. 362, as amended by Pub. L. 99-272, title IX, §9123(a), Apr. 7, 1986, 100 Stat. 168, provided that: “The amendments made by this section [amending this section and sections 1395d to 1395f, 1395h, and 1395x to 1395cc of this title and section 231f of Title 45, Railroads, and enacting provisions set out as notes under sections 1395b-1 and 1395f of this title] apply to hospice care provided on or after November 1, 1983.”

Amendment by section 278(b)(3) of Pub. L. 97-248 effective on and after Jan. 1, 1983, and applicable to remuneration (for medicare qualified Federal employment) paid after Dec. 31, 1982, see section 278(c)(2)(A) of Pub. L. 97-248, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96-499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96-499, set out as a note under section 1395x of this title.

Amendment by Pub. L. 96-473 effective after second month beginning after Oct. 19, 1980, see section 2(d) of Pub. L. 96-473, set out as a note under section 426 of this title.

Amendment by Pub. L. 96-265 applicable with respect to hospital insurance or supplementary medical insurance benefits for services provided on or after first day of sixth month which begins after June 9, 1980, see section 103(c) of Pub. L. 96-265, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95-292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95-292, set out as a note under section 426 of this title.

ADVISORY COUNCIL TO STUDY COVERAGE OF DISABLED UNDER THIS SUBCHAPTER

Pub. L. 90-248, title I, §140, Jan. 2, 1968, 81 Stat. 854, directed Secretary of Health, Education, and Welfare to appoint an Advisory Council to study need for coverage of disabled under the health insurance programs of this subchapter, directed Council to submit a report on such study to Secretary by Jan. 1, 1969, and directed Secretary in turn to transmit such report to Congress, resulting in termination of Council's existence.

REIMBURSEMENT OF CHARGES UNDER PART A FOR SERVICES TO PATIENTS ADMITTED PRIOR TO 1968 TO CERTAIN HOSPITALS

Pub. L. 90-248, title I, §142, Jan. 2, 1968, 81 Stat. 855, provided that:

“(a) Notwithstanding any provision of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], an individual who is entitled to hospital insurance benefits under section 226 of such Act [42 U.S.C. 426] may, subject to subsections (b) and (c), receive, on the basis of an itemized bill, reimbursement for charges to him for inpatient hospital services (as defined in section 1861 of such Act [42 U.S.C. 1395x], but without regard to subsection (e) of such section) furnished by, or under arrangements (as defined in section 1861(w) of such Act [42 U.S.C. 1395x(w)]) with, a hospital if—

“(1) the hospital did not have an agreement in effect under section 1866 of such Act [42 U.S.C. 1395cc] but would have been eligible for payment under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] with respect to such services if at the time such services were furnished the hospital had such an agreement in effect;

“(2) the hospital (A) meets the requirements of paragraphs (5) and (7) of section 1861(e) of such Act [42 U.S.C. 1395x(e)(5), (7)], (B) is not primarily engaged in providing the services described in section 1961(j)(1)(A) of such Act [42 U.S.C. 1395x(j)(1)(A)], and (C) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1)

of section 1861(r) of such Act [42 U.S.C. 1395x(r)(1)], to inpatients (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

“(3) the hospital did not meet the requirements that must be met to permit payment to the hospital under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.]; and

“(4) an application is filed (submitted in such form and manner and by such person, and containing and supported by such information, as the Secretary shall by regulations prescribe) for reimbursement before January 1, 1969.

“(b) Payments under this section may not be made for inpatient hospital services (as described in subsection (a)) furnished to an individual—

“(1) prior to July 1, 1966,

“(2) after December 31, 1967, unless furnished with respect to an admission to the hospital prior to January 1, 1968, and

“(3) for more than—

“(A) 90 days in any spell of illness, but only if (i) prior to January 1, 1969, the hospital furnishing such services entered into an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] and (ii) the hospital’s plan for utilization review, as provided for in section 1861(k) of such Act [42 U.S.C. 1395x(k)], has, in accordance with section 1814 of such Act [42 U.S.C. 1395f], been applied to the services furnished such individual, or

“(B) 20 days in any spell of illness, if the hospital did not meet the conditions of clauses (i) and (ii) of subparagraph (A).

“(c)(1) The amounts payable in accordance with subsection (a) with respect to inpatient hospital services shall, subject to paragraph (2) of this subsection, be paid from the Federal Hospital Insurance Trust Fund in amounts equal to 60 percent of the hospital’s reasonable charges for routine services furnished in the accommodations occupied by the individual or in semi-private accommodations (as defined in section 1861(v)(4) of the Social Security Act [42 U.S.C. 1395x(v)(4)]) whichever is less, plus 80 percent of the hospital’s reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital’s reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semi-private accommodations (as so defined). For purposes of the preceding provisions of this paragraph, the term ‘routine services’ shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term ‘ancillary services’ shall mean those special services for which charges are customarily made in addition to routine services.

“(2) Before applying paragraph (1), payments made under this section shall be reduced to the extent provided for under section 1813 of the Social Security Act [42 U.S.C. 1395e] in the case of benefits payable to providers of services under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.].

“(d) For the purposes of this section—

“(1) the 90-day period, referred to in subsection (b)(3)(A), shall be reduced by the number of days of inpatient hospital services furnished to such individual during the spell of illness, referred to therein, and with respect to which he was entitled to have payment made under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.];

“(2) the 20-day period, referred to in subsection (b)(3)(B) shall be reduced by the number of days in excess of 70 days of inpatient hospital services furnished during the spell of illness, referred to therein, and with respect to which such individual was entitled to have payment made under such part A [42 U.S.C. 1395c et seq.];

“(3) the term ‘spell of illness’ shall have the meaning assigned to it by subsection (a) of section 1861 of such Act [42 U.S.C. 1395x(a)] except that the term ‘inpatient hospital services’ as it appears in such subsection shall have the meaning assigned to it by subsection (a) of this section.”

§ 1395d. Scope of benefits

(a) Entitlement to payment for inpatient hospital services, post-hospital extended care services, home health services, and hospice care

The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1395f(d)(2) of this title to him (subject to the provisions of this part) for—

(1) inpatient hospital services or inpatient critical access hospital services for up to 150 days during any spell of illness minus 1 day for each day of such services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f) of this section, extended care services that are not post-hospital extended care services;

(3) in the case of individuals not enrolled in part B of this subchapter, home health services, and in the case of individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness;

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1) of this section; and

(5) for individuals who are terminally ill, have not made an election under subsection (d)(1) of this section, and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1395x(r)(1) of this title) who is either the medical director or an employee of a hospice program and that—

(A) consist of—

(i) an evaluation of the individual’s need for pain and symptom management, including the individual’s need for hospice care; and

(ii) counseling the individual with respect to hospice care and other care options; and

(B) may include advising the individual regarding advanced care planning.

(b) Services not covered

Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c) of this section) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have

been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

Payment under this part for post-institutional home health services furnished an individual during a home health spell of illness may not be made for such services beginning after such services have been furnished for a total of 100 visits during such spell.

(c) Inpatients of psychiatric hospitals

If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) of this section insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3) of this section).

(d) Hospice care; election; waiver of rights; revocation; change of election

(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each and an unlimited number of subsequent periods of 60 days each during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this subchapter.

(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this subchapter with respect to—

(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or

(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

(B) After an individual makes such an election with respect to a 90-day period or a subsequent 60-day period, the individual may revoke the election during the period, in which case—

(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) of this section and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

(D) For purposes of this subchapter, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

(e) Services taken into account

For purposes of subsections (b) and (c) of this section, inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1395f(a) of this title, made with respect to such services under this part.

(f) Coverage of extended care services without regard to three-day prior hospitalization requirement

(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2) of this section, of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this subchapter and will not alter the acute care nature of the benefit described in subsection (a)(2) of this section.

(2) The Secretary may provide—

(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) of this section and on the categories of individuals who may be eligible to receive such services, and

(B) notwithstanding sections 1395f, 1395x(v), and 1395ww of this title, for such restrictions

and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

(g) "Spell of illness" defined

For definitions of "spell of illness", and for definitions of other terms used in this part, see section 1395x of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1812, as added Pub. L. 89-97, title I, §102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 90-248, title I, §§129(c)(2), 137(a), 138(a), 143(b), 146(a), Jan. 2, 1968, 81 Stat. 847, 853, 854, 857, 859; Pub. L. 96-499, title IX, §§930(b)-(d), 931(a), Dec. 5, 1980, 94 Stat. 2631, 2633; Pub. L. 97-35, title XXI, §2121(a), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97-248, title I, §§122(b), 123, Sept. 3, 1982, 96 Stat. 356, 364; Pub. L. 97-448, title III, §309(b)(5), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 100-360, title I, §101, July 1, 1988, 102 Stat. 684; Pub. L. 101-234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101-239, title VI, §6003(g)(3)(B)(i), Dec. 19, 1989, 103 Stat. 2152; Pub. L. 101-508, title IV, §4006(a), Nov. 5, 1990, 104 Stat. 1388-43; Pub. L. 103-432, title I, §102(g)(1), Oct. 31, 1994, 108 Stat. 4404; Pub. L. 105-33, title IV, §§4201(c)(1), 4443(a), (b)(1), 4611(a), Aug. 5, 1997, 111 Stat. 373, 423, 472; Pub. L. 106-113, div. B, §1000(a)(6) [title III, §321(k)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A-366; Pub. L. 108-173, title V, §512(a), title VII, §736(c)(1), Dec. 8, 2003, 117 Stat. 2299, 2356.)

AMENDMENTS

2003—Subsec. (a)(3). Pub. L. 108-173, §736(c)(1), substituted "in the case of individuals not" for "for individuals not" and "in the case of individuals so" for "for individuals so".

Subsec. (a)(5). Pub. L. 108-173, §512(a), added par. (5). 1999—Subsec. (b). Pub. L. 106-113 inserted "during" after "100 visits" in concluding provisions.

1997—Subsec. (a)(1). Pub. L. 105-33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (a)(3). Pub. L. 105-33, §4611(a)(1), substituted "for individuals not enrolled in part B of this subchapter, home health services, and for individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness" for "home health services".

Subsec. (a)(4). Pub. L. 105-33, §4443(a), substituted "and an unlimited number of subsequent periods of 60 days each" for "a subsequent period of 30 days, and a subsequent extension period".

Subsec. (b). Pub. L. 105-33, §4611(a)(2), inserted closing provisions.

Subsec. (d)(1). Pub. L. 105-33, §4443(a), substituted "and an unlimited number of subsequent periods of 60 days each" for "a subsequent period of 30 days, and a subsequent extension period".

Subsec. (d)(2)(B). Pub. L. 105-33, §4443(b)(1), substituted "90-day period or a subsequent 60-day period" for "90- or 30-day period or a subsequent extension period".

1994—Subsec. (a)(1). Pub. L. 103-432 substituted "inpatient hospital services or inpatient rural primary care hospital services" for "inpatient hospital services" before "for up to 150 days" and "such services" for "inpatient hospital services" before "in excess of 90" and struck out "and inpatient rural primary care hospital services" after "such payment made)".

1990—Subsec. (a)(4). Pub. L. 101-508, §4006(a)(1), substituted "90 days each, a subsequent period of 30 days, and a subsequent extension period" for "90 days each and one subsequent period of 30 days".

Subsec. (d)(1). Pub. L. 101-508, §4006(a)(2)(A), substituted "90 days each, a subsequent period of 30 days, and a subsequent extension period during the individual's lifetime" for "90 days each and one subsequent period of 30 days during the individual's lifetime".

Subsec. (d)(2)(B). Pub. L. 101-508, §4006(a)(2)(B), substituted "a 90- or 30-day period or a subsequent extension period" for "a 90- or 30-day period".

1989—Subsec. (a). Pub. L. 101-234 repealed Pub. L. 100-360, §101(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1). Pub. L. 101-239 inserted "and inpatient rural primary care hospital services" before semicolon at end.

Subsecs. (b) to (d)(1), (2)(B), (e) to (g). Pub. L. 101-234 repealed Pub. L. 100-360, §101(2)-(6), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (a). Pub. L. 100-360, §101(1), struck out former pars. (1) to (4) and added new pars. (1) to (4) which read as follows:

"(1) inpatient hospital services;

"(2) extended care services for up to 150 days during any calendar year;

"(3) home health services; and

"(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (d)(1) of this section."

Subsec. (b). Pub. L. 100-360, §101(2), amended subsec. (b) generally, striking out par. (1) and renumbering and amending pars. (2) and (3) as (1) and (2), respectively.

Subsec. (c). Pub. L. 100-360, §101(3), amended subsec. (c) generally, substituting pars. (1) to (4) limiting periods for inpatients of psychiatric hospitals for former single paragraph.

Subsec. (d)(1). Pub. L. 100-360, §101(4)(A), substituted "a subsequent period of 30 days, and a subsequent extension period" for "and one subsequent period of 30 days".

Subsec. (d)(2)(B). Pub. L. 100-360, §101(4)(B), inserted "or a subsequent extension period" after "30-day period" in introductory provisions.

Subsec. (e). Pub. L. 100-360, §101(5), struck out "post-hospital" before "extended care services".

Subsec. (f). Pub. L. 100-360, §101(6), struck out subsec. (f) which provided coverage of extended care services without regard to three-day prior hospitalization requirement.

Subsec. (g). Pub. L. 100-360, §101(6), struck out subsec. (g) which cross-referenced section 1395x of this title for definitions of "spell of illness" and other terms used in this part.

1983—Subsec. (d)(2)(A). Pub. L. 97-448 substituted "or to services" for "or to other than services" after "(if not an employee of the hospice program)".

1982—Subsec. (a)(2). Pub. L. 97-248, §123(a), redesignated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(4). Pub. L. 97-248, §122(b)(1), added par. (4).

Subsec. (d). Pub. L. 97-248, §122(b)(2), added subsec. (d).

Subsecs. (f), (g). Pub. L. 97-248, §123(b), added subsec. (f) and redesignated former subsec. (f) as (g).

1981—Subsec. (a). Pub. L. 97-35 struck out par. (4) which related to alcohol detoxification facility services.

1980—Subsec. (a)(3). Pub. L. 96-499, §930(b), substituted "home health services" for "post-hospital home health services for up to 100 visits (during the one-year period described in section 1395x(n) of this title) after the beginning of one spell of illness and before the beginning of the next".

Subsec. (a)(4). Pub. L. 96-499, §931(a), added par. (4).

Subsec. (d). Pub. L. 96-499, §930(c), struck out subsec. (d) which authorized payment for post-hospital home

health services furnished an individual only during the one year period described in section 1395x(n) of this title following his most recent hospital discharge which met the requirements of such section and only for the first 100 visits in such period.

Subsec. (e). Pub. L. 96-499, §930(d), substituted “subsections (b) and (c)” for “subsections (b), (c), and (d)” and “and post-hospital extended care services” for “post-hospital extended care services, and post-hospital home health services”.

1968—Subsec. (a). Pub. L. 90-248, §143(b), inserted “or, in the case of payments referred to in section 1395f(d)(2) of this title to him” after “on his behalf” in text preceding par. (1).

Subsec. (a)(1). Pub. L. 90-248, §137(a)(1), increased the maximum duration of benefits from 90 to 150 days minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies that he does not desire to have such payment made).

Subsec. (a)(4). Pub. L. 90-248, §129(c)(2), struck out par. (4) which provided for payment for outpatient hospital diagnostic services.

Subsec. (b)(1). Pub. L. 90-248, §137(a)(2), changed the limitation on payments from 90 to 150 days minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies that he does not desire to have such payment made).

Subsec. (c). Pub. L. 90-248, §138(a), increased the limit from 90 to 150 days so that if an individual was an inpatient of a psychiatric or tuberculosis hospital on the first day of the first month for which he is entitled to benefits, the days he was an inpatient in the 150-day period immediately before such first day are included in determining the limit under subsec. (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services and inpatient tuberculosis hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness or tuberculosis (but are not included in determining such limit as it applies to other inpatient hospital services or in determining the 190-day limit under subsec. (b)(3)).

Pub. L. 90-248, §146(a), provided that the limitation of allowable days of inpatient hospital services will not apply to services provided to an inpatient of a tuberculosis hospital.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title V, §512(d), Dec. 8, 2003, 117 Stat. 2300, provided that: “The amendments made by this section [amending this section and sections 1395f and 1395x of this title] shall apply to services provided by a hospice program on or after January 1, 2005.”

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106-113, div. B, §1000(a)(6) [title III, §321(m)], Nov. 29, 1999, 113 Stat. 1536, 1501A-368, provided that: “Except as otherwise provided, the amendments made by this section [amending this section and sections 1395i, 1395i-4, 1395f, 1395m, 1395u, 1395w-3, 1395w-4, 1395w-21, 1395w-22, 1395w-24, 1395x, 1395y, 1395cc, 1395ss, 1395ww, 1395yy, and 1395fff of this title, repealing section 1320b-5 of this title, and amending provisions set out as notes under sections 1395f and 1395ww of this title] shall take effect as if included in the enactment of BBA [Balanced Budget Act of 1997, Pub. L. 105-33].”

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(c)(1) of Pub. L. 105-33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105-33, set out as a note under section 1395f of this title.

Pub. L. 105-33, title IV, §4449, Aug. 5, 1997, 111 Stat. 424, provided that: “Except as otherwise provided in

this chapter [chapter 4 (§§4441-4449) of subtitle E of title IV of Pub. L. 105-33, amending this section and sections 1395f, 1395x, and 1395pp of this title and enacting provisions set out as notes under section 1395f and 1395x of this title], the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter [Aug. 5, 1997], regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.”

Pub. L. 105-33, title IV, §4611(f), Aug. 5, 1997, 111 Stat. 474, provided that: “The amendments made by this section [amending this section and sections 1395u, 1395x, and 1395ff of this title] apply to services furnished on or after January 1, 1998. For purpose of applying such amendments, any home health spell of illness that began, but not [sic] did not end, before such date shall be considered to have begun as of such date.”

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103-432, title I, §102(i), Oct. 31, 1994, 108 Stat. 4404, provided that: “The amendments made by this section [amending this section and sections 1395e, 1395f, 1395i-4, 1395m, 1395x, and 1395ww of this title] shall take effect on the date of the enactment of this Act [Oct. 31, 1994].”

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101-508, title IV, §4006(c), Nov. 5, 1990, 104 Stat. 1388-43, provided that: “The amendments made by this section [amending this section and section 1395f of this title] shall apply with respect to care and services furnished on or after January 1, 1990.”

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101-234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101-234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100-360, title I, §104(a), July 1, 1988, 102 Stat. 687, as amended by Pub. L. 100-485, title VI, §608(d)(3)(A), Oct. 13, 1988, 102 Stat. 2413, provided that:

“(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (b), the amendments made by this subtitle [subtitle A (§§101-104) of title I of Pub. L. 100-360, amending this section and sections 1395c, 1395e, 1395f, 1395i-2, 1395k, 1395x, 1395cc, and 1395tt of this title] shall take effect on January 1, 1989, and shall apply—

“(A) to the inpatient hospital deductible for 1989 and succeeding years,

“(B) to care and services furnished on or after January 1, 1989,

“(C) to premiums for January 1989 and succeeding months, and

“(D) to blood or blood cells furnished on or after January 1, 1989.

“(2) ELIMINATION OF POST-HOSPITAL REQUIREMENT FOR EXTENDED CARE SERVICES.—The amendments made by this subtitle, insofar as they eliminate the requirement (under section 1812(a)(2) of the Social Security Act [42 U.S.C. 1395d(a)(2)]) that extended care services are only covered under title XVIII of such Act [42 U.S.C. 1395 et seq.] if they are post-hospital extended care services, shall only apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989.”

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97-448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, see section 309(c)(2) of Pub. L. 97-448, set out as a note under section 426-1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(b) of Pub. L. 97-248 applicable to hospice care provided on or after Nov. 1, 1983,

see section 122(h)(1) of Pub. L. 97-248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97-35, title XXI, §2121(i), Aug. 13, 1981, 95 Stat. 796, provided that: "The amendments made by this section [amending this section and sections 1320c-3, 1320c-4, 1320c-7, 1395f, and 1395x of this title] (other than by subsection (h) [repealing provisions set out as a note under section 1395l of this title]) shall apply to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after the date of the enactment of this Act [Aug. 13, 1981]."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 930(b)-(d) of Pub. L. 96-499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96-499, set out as a note under section 1395x of this title.

Pub. L. 96-499, title IX, §931(e), Dec. 5, 1980, 94 Stat. 2634, provided that: "The amendments made by subsections (a) through (d) of this section [amending this section and sections 1395f and 1395x of this title] shall become effective on April 1, 1981."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90-248, title I, §129(d), Jan. 2, 1968, 81 Stat. 849, provided that: "The amendments made by this section [amending this section and sections 426, 1395e, 1395f, 1395k, 1395l, 1395n, 1395x, and 1395cc of this title and section 228s-2 of Title 45, Railroads] shall apply with respect to services furnished after March 31, 1968, except that subsection (c)(5) of such section [amending section 1395f of this title] shall become effective with respect to services furnished after the date of enactment of this Act [Jan. 2, 1968]."

Pub. L. 90-248, title I, §137(c), Jan. 2, 1968, 81 Stat. 854, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395e of this title] shall apply with respect to services furnished after December 31, 1967."

Pub. L. 90-248, title I, §138(b), Jan. 2, 1968, 81 Stat. 854, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to payment for services furnished after December 31, 1967."

Pub. L. 90-248, title I, §143(d), Jan. 2, 1968, 81 Stat. 858, provided that: "The provisions made by subsection (a) of this section [amending section 1395x of this title] shall become effective as of July 1, 1966, and the provisions made by subsections (b) and (c) of this section [amending this section and section 1395f of this title] shall apply to services furnished with respect to admissions occurring after December 31, 1967, and to outpatient hospital diagnostic services furnished after December 31, 1967, and before April 1, 1968."

Pub. L. 90-248, title I, §146(b), Jan. 2, 1968, 81 Stat. 859, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to payment for services furnished after December 31, 1967."

MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM

Pub. L. 111-148, title III, §3140, Mar. 23, 2010, 124 Stat. 440, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

"(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

"(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration

program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

"(b) INDEPENDENT EVALUATION AND REPORTS.—

"(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

"(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

"(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII [42 U.S.C. 1395 et seq.] for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented."

PROTECTING HOME HEALTH BENEFITS

Pub. L. 111-148, title III, §3143, Mar. 23, 2010, 124 Stat. 442, provided that: "Nothing in the provisions of, or amendments made by, this Act [see Short Title note set out under section 18001 of this title] shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

RURAL HOSPICE DEMONSTRATION PROJECT

Pub. L. 108-173, title IV, §409, Dec. 8, 2003, 117 Stat. 2271, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the facility for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

"(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

"(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

"(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395x(dd)(2)(A)(iii)]; and

"(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act [42 U.S.C. 1395 et seq.].

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

"(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas."

OIG REPORT ON NOTICES RELATING TO USE OF HOSPITAL LIFETIME RESERVE DAYS

Pub. L. 108-173, title IX, §953(d), Dec. 8, 2003, 117 Stat. 2428, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

“(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

“(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.”

MEDPAC REPORT ON ACCESS TO, AND USE OF, HOSPICE BENEFIT

Pub. L. 106-554, §1(a)(6) [title III, §323], Dec. 21, 2000, 114 Stat. 2763, 2763A-501, provided that:

“(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study to examine the factors affecting the use of hospice benefits under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], including a delay in the time (relative to death) of entry into a hospice program, and differences in such use between urban and rural hospice programs and based upon the presenting condition of the patient.

“(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Commission deems appropriate.”

TRANSITION

Pub. L. 105-33, title IV, §4611(e), Aug. 5, 1997, 111 Stat. 473, provided that:

“(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the Secretary of Health and Human Services shall establish a transition for the aggregate amount of expenditures that are transferred from part A, to part B, of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], as a result of the amendments made by this section [amending this section and sections 1395u, 1395x, and 1395ff of this title], during each of the years during the period beginning with 1998 and ending with 2002 according to this subsection. Under the transition for each such year, the Secretary shall effect such transfer, between the trust funds under such parts, as will result in only the proportion (specified in paragraph (2)) of such aggregate expenditures for the year being transferred from such part A to such part B.

“(2) PROPORTION SPECIFIED.—The proportion specified in this paragraph for—

“(A) 1998 is $\frac{1}{6}$,

“(B) 1999 is $\frac{1}{3}$,

“(C) 2000 is $\frac{1}{2}$,

“(D) 2001 is $\frac{2}{3}$, and

“(E) 2002 is $\frac{5}{6}$.

“(3) APPLICATION IN ESTABLISHING MONTHLY PREMIUMS FOR 1998 THROUGH 2003.—

“(A) IN GENERAL.—For purposes only of computing the monthly premium under section 1839 of the Social Security Act (42 U.S.C. 1395r), the monthly actuarial rate for enrollees age 65 and over shall be computed as though any reference in paragraph (1) of this subsection to 2002 were a reference to 2003 and as if the following proportions were substituted for the proportions specified in paragraph (2):

“(i) For 1998, $\frac{1}{7}$.

“(ii) For 1999, $\frac{2}{7}$.

“(iii) For 2000, $\frac{3}{7}$.

“(iv) For 2001, $\frac{4}{7}$.

“(v) For 2002, $\frac{5}{7}$.

“(vi) For 2003, $\frac{6}{7}$.

“(B) NO IMPACT ON GOVERNMENT CONTRIBUTION.—Subparagraph (A) does not apply in determining the amount of the Government contribution under section 1844 of the Social Security Act (42 U.S.C. 1395w).”

REPEAL OF 1988 EXPANSION OF MEDICARE PART A BENEFITS

For provisions repealing amendment by section 101 of Pub. L. 100-360, restoring or reviving this section as if

section 101 of Pub. L. 100-360 had not been enacted, and providing a transition period for medicare beneficiaries with respect to inpatient hospital services and extended care services provided on or after Jan. 1, 1990, and providing an exception to such restoration for certain hospice care, see section 101(a)-(b)(2) of Pub. L. 101-234, set out as a note under section 1395e of this title.

§ 1395e. Deductibles and coinsurance

(a) Inpatient hospital services; outpatient hospital diagnostic services; blood; post-hospital extended care services

(1) The amount payable for inpatient hospital services or inpatient critical access hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1395d(a)(1) of this title to have payment made on his behalf for inpatient hospital services or inpatient critical access hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such in-

dividual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1395f(b) of this title to blood or blood cells furnished the individual in the year.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

(4)(A) The amount payable for hospice care shall be reduced—

(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed \$5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1395f(i) of this title to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term “hospice coinsurance period” means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1395d(d) of this title is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

(B) During the period of an election by an individual under section 1395d(d)(1) of this title, no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

(b) Inpatient hospital deductible; application

(1) The inpatient hospital deductible for 1987 shall be \$520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied under section 1395ww(d)(3)(A) of this title for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the

basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of \$4 shall be rounded to the nearest multiple of \$4 (or, if it is midway between two multiples of \$4, to the next higher multiple of \$4).

(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

(3) The inpatient hospital deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) of this section for the year in which the first day of inpatient hospital services or inpatient critical access hospital services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) of this section for inpatient hospital services, inpatient critical access hospital services and post-hospital extended care services furnished in that year.

(Aug. 14, 1935, ch. 531, title XVIII, §1813, as added Pub. L. 89-97, title I, §102(a), July 30, 1965, 79 Stat. 292; amended Pub. L. 90-248, title I, §§129(c)(3), (4), 135(a), 137(b), Jan. 2, 1968, 81 Stat. 847, 848, 852, 854; Pub. L. 97-35, title XXI, §§2131(a), 2132(a), Aug. 13, 1981, 95 Stat. 797; Pub. L. 97-248, title I, §122(e), Sept. 3, 1982, 96 Stat. 361; Pub. L. 99-272, title IX, §9125(a), Apr. 7, 1986, 100 Stat. 168; Pub. L. 99-509, title IX, §9301(a), Oct. 21, 1986, 100 Stat. 1981; Pub. L. 100-203, title IV, §4002(f)(3), Dec. 22, 1987, as added Pub. L. 100-360, title IV, §411(b)(1)(H)(ii), July 1, 1988, 102 Stat. 769; Pub. L. 100-360, title I, §102, July 1, 1988, 102 Stat. 685; Pub. L. 101-234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 103-432, title I, §102(g)(2), (3), Oct. 31, 1994, 108 Stat. 4404; Pub. L. 105-33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373.)

AMENDMENTS

1997—Pub. L. 105-33 substituted “critical access” for “rural primary care” wherever appearing.

1994—Subsec. (a)(1). Pub. L. 103-432, §102(g)(2), substituted “inpatient hospital services or inpatient rural primary care hospital services” for “inpatient hospital services” in introductory provisions and in subpar. (B).

Subsec. (b)(3)(A). Pub. L. 103-432, §102(g)(2), substituted “inpatient hospital services or inpatient rural primary care hospital services” for “inpatient hospital services”.

Subsec. (b)(3)(B). Pub. L. 103-432, §102(g)(3), substituted “inpatient hospital services, inpatient rural primary care hospital services” for “inpatient hospital services”.

1989—Subsecs. (a)(1) to (3), (b)(3). Pub. L. 101-234 repealed Pub. L. 100-360, §102, subject to an exception for blood deduction, and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (a)(1) to (3). Pub. L. 100-360, §102(1), amended pars. (1) to (3) generally, revising and reorganizing former pars. (1)(A), (B), (2), and (3), as par. (1), consisting of subpars. (A) to (D), and pars. (2) and (3), each consisting of subpars. (A) and (B).

Subsec. (b)(1). Pub. L. 100-360, §411(b)(1)(H)(ii), added Pub. L. 100-203, §4002(f)(3), see 1987 Amendment note below.

Subsec. (b)(3). Pub. L. 100-360, §102(2), struck out par. (3) which related to application of deductible.

1987—Subsec. (b)(1). Pub. L. 100-203, §4002(f)(3), as added by Pub. L. 100-360, §411(b)(1)(H)(ii), substituted

“Secretary’s best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied” for “applicable percentage increase (as defined in section 1395ww(b)(3)(B) of this title) which is applied”.

1986—Subsec. (b). Pub. L. 99-509 amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows:

“(1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) of this section shall be \$40 in the case of any spell of illness beginning before 1969.

“(2) The Secretary shall, between July 1 and September 15 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) of this section in the case of any inpatient hospital services or post-hospital extended care services furnished during the succeeding calendar year. Such inpatient hospital deductible shall be equal to \$45 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of \$4 shall be rounded to the nearest multiple of \$4 (or, if it is midway between two multiples of \$4, to the next higher multiple of \$4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1395cc of this title, to individuals who are entitled to hospital insurance benefits under section 426 of this title, plus the amount which would have been so paid but for subsection (a)(1) of this section.”

Subsec. (b)(2). Pub. L. 99-272 substituted “September 15” for “October 1”.

1982—Subsec. (a)(4). Pub. L. 97-248 added par. (4).

1981—Subsec. (b)(2). Pub. L. 97-35 substituted “any inpatient hospital services or post-hospital extended care services furnished during the succeeding calendar year. Such inpatient hospital deductible shall be equal to \$45” for “any spell of illness beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to \$40”.

1968—Subsec. (a)(1). Pub. L. 90-248, §137(b), designated existing provisions as subpar. (A) and added subpar. (B) and the exception provision that the reduction for any day shall not exceed the charges for that day.

Subsec. (a)(2). Pub. L. 90-248, §135(a), made the three pint deductible applicable also to equivalent quantities of packed red blood cells, as defined by the Secretary under regulations.

Subsec. (a)(2) to (4). Pub. L. 90-248, §129(c)(3), struck out par. (2) which provided for reduction of amount payable for outpatient hospital diagnostic services furnished an individual during a diagnostic study, and redesignated pars. (3) and (4) as (2) and (3), respectively.

Subsec. (b)(1), (2). Pub. L. 90-248, §129(c)(4)(A), (B), struck out diagnostic studies from application of inpatient hospital deductible.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105-33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101-234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101-234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 102 of Pub. L. 100-360 effective Jan. 1, 1989, except as otherwise provided, and applica-

ble to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100-360, set out as a note under section 1395d of this title.

Pub. L. 100-360, title IV, §411(b)(1)(H)(iii), July 1, 1988, 102 Stat. 769, provided that: “The amendment made by clause (ii) [amending Pub. L. 100-203] shall apply to the inpatient hospital deductible for years beginning with 1989.”

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99-509, title IX, §9301(b), Oct. 21, 1986, 100 Stat. 1982, provided that: “The amendment made by subsection (a) [amending this section] shall apply to inpatient hospital services and post-hospital extended care services furnished on or after January 1, 1987, and to the monthly premium (under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.]) for months beginning with January 1987.”

Pub. L. 99-272, title IX, §9125(b), Apr. 7, 1986, 100 Stat. 168, provided that: “The amendment made by this section [amending this section] shall apply to calendar years after 1985.”

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97-248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97-248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97-35, title XXI, §2131(b), Aug. 13, 1981, 95 Stat. 797, provided that: “The amendment made by subsection (a) [amending this section] is effective for inpatient hospital services or post-hospital extended care services furnished on or after January 1, 1982.”

Pub. L. 97-35, title XXI, §2132(b), Aug. 13, 1981, 95 Stat. 797, provided that: “The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services and post-hospital extended care services furnished in calendar years beginning with calendar year 1982.”

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(3), (4) of Pub. L. 90-248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90-248, set out as a note under section 1395d of this title.

Pub. L. 90-248, title I, §135(d), Jan. 2, 1968, 81 Stat. 853, provided that: “The amendments made by this section [amending this section and sections 1395f and 1395cc of this title] shall apply with respect to payment for blood (or packed red blood cells) furnished an individual after December 31, 1967.”

Amendment by section 137(b) of Pub. L. 90-248 applicable with respect to services furnished after Dec. 31, 1967, see section 137(c) of Pub. L. 90-248, set out as a note under section 1395d of this title.

REPEAL OF 1988 EXPANSION OF MEDICARE PART A BENEFITS

Pub. L. 101-234, title I, §101(a)-(b)(2), Dec. 13, 1989, 103 Stat. 1979, as amended by Pub. L. 101-508, title IV, §4008(m)(1), Nov. 5, 1990, 104 Stat. 1388-53, provided that: “(a) IN GENERAL.—

“(1) GENERAL RULE.—Except as provided in paragraph (2), sections 101, 102, and 104(d) (other than paragraph (7)) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) [amending this section and sections 1395c, 1395d, 1395f, 1395k, 1395x, 1395cc, and 1395tt of this title] (in this Act referred to as ‘MCCA’) are repealed, and the provisions of law amended or repealed by such sections are restored or revived as if such section had not been enacted.

“(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA [amending this section] (relating to deductibles and coinsurance under part A)

shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act [42 U.S.C. 1395e(a)(2)] (relating to a deduction for blood).

“(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

“(1) INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL EXTENDED CARE SERVICES.—In applying sections 1812 and 1813 of the Social Security Act [42 U.S.C. 1395d, 1395e], as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—

“(A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;

“(B) with respect to the limitation (other than the limitation under section 1812(c) of such Act [42 U.S.C. 1395d(c)]) on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted, except that days of inpatient hospital services before January 1, 1989, which were applied with respect to an individual after receiving 90 days of services in a spell of illness (commonly known as ‘lifetime reserve days’) shall be counted;

“(C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services; and

“(D) the inpatient hospital deductible under section 1813(a)(1) of such Act [42 U.S.C. 1395e(a)(1)] shall not apply—

“(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, with respect to the spell of illness beginning on such date, if such a deductible was imposed on the individual for a period of hospitalization during 1989;

“(ii) for a spell of illness beginning during January 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989; and

“(iii) in the case of a spell of illness of an individual that began before January 1, 1990.

“(2) HOSPICE CARE.—The restoration of section 1812(a)(4) of the Social Security Act [42 U.S.C. 1395d(a)(4)], effected by subsection (a)(1), shall not apply to hospice care provided during the subsequent period (described in such section as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990.”

[Pub. L. 101-508, title IV, § 4008(m)(1), Nov. 5, 1990, 104 Stat. 1388-53, provided that amendment by that section to section 101(b)(1)(B) of Pub. L. 101-234, set out above, is effective as if included in enactment of Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. 101-234.]

HOLD HARMLESS PROVISIONS; APPLICATION OF SUBSECTION (a)(1) AND (2)

Pub. L. 100-360, title I, § 104(b), July 1, 1988, 102 Stat. 688, as amended by Pub. L. 100-485, title VI, § 608(d)(3)(B), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101-234, title I, § 101(b)(3), Dec. 13, 1989, 103 Stat. 1980, provided that: “In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act [42 U.S.C. 1395x(a)], as in effect on December 31, 1988) began before January 1, 1989, and had not yet ended as of such date—

“(1)(A) section 1813(a)(1) of such Act [subsec. (a)(1) of this section] (as amended by this subtitle [subtitle A (§§ 101-104) of title I of Pub. L. 100-360]) shall not apply to services furnished during that spell of illness during 1989, and

“(B) if that individual begins a period of hospitalization (as defined in such section) during 1989

after the end of that spell of illness, the first period of hospitalization during 1989 that begins after that spell of illness shall be considered to be (for purposes of such section) the first period of hospitalization that begins during that year; and

“(2) the amount of any deductible under section 1813(a)(2) of such Act (as amended by this subtitle) shall be reduced during that spell of illness during 1989 to the extent the deductible under such section was applied during the spell of illness.”

PROMULGATION OF NEW DEDUCTIBLE

Pub. L. 99-509, title IX, § 9301(c), Oct. 21, 1986, 100 Stat. 1982, directed Secretary of Health and Human Services to provide, within 30 days after Oct. 21, 1986, for publication of inpatient hospital deductible, coinsurance amounts for inpatient hospital services and post-hospital extended care services, and monthly part A premiums for 1987, as modified under the amendment of this section made by subsection (a).

§ 1395f. Conditions of and limitations on payment for services

(a) Requirement of requests and certifications

Except as provided in subsections (d) and (g) of this section and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service;

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1395x(aa)(5) of this title) who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,¹ or, in the case of services described in subparagraph (C), a physician enrolled under section 1395cc(j) of this title, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of post-hospital extended care services, such services are or were re-

¹ So in original.

quired to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1395x(e) of this title) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; such services are or were furnished while the individual was under the care of a physician, and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician, has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1395m(m) of this title, and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary; or

(D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital

services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1395cc(d) of this title (based on a finding that utilization review of long-stay cases is not being made in such hospital);

(6) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1395x(k)(4) of this title, including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding;

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1395x(dd)(3)(B) of this title) (which for purposes of this subparagraph does not include a nurse practitioner), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program providing (or arranging for) the care,

each certify in writing at the beginning of the period, that the individual is terminally ill (as defined in section 1395x(dd)(3)(A) of this title) based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness, and

(ii) in a subsequent 90- or 60-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill based on such clinical judgment;

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director (and the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program;

(C) such care is being or was provided pursuant to such plan of care;

(D) on and after January 1, 2011 (and, in the case of clause (ii), before October 6, 2014)—

(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this subchapter, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and

(E) on and after October 6, 2014, in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of all cases of individuals provided hospice care by the program under this subchapter, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and

(8) in the case of inpatient critical access hospital services, a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall

become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(b) Amount paid to provider of services

The amount paid to any provider of services (other than a hospice program providing hospice care, other than a critical access hospital providing inpatient critical access hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e, 1395ww, and 1395fff of this title, be—

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its pa-

tients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then, subject to section 1395ww(d)(3)(B)(ix)(III)² of this title, the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the aggregate rate of increase from January 1, 1981, to the most recent date for which annual data are available in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the condi-

tions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system. For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1395ww of this title.

(c) No payments to Federal providers of services

Subject to section 1395qq of this title, no payment may be made under this part (except under subsection (d) or subsection (h) of this section) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

(d) Payments for emergency hospital services

(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital insurance benefits under section 426 of this title even though such hospital does not have an agreement in effect under this subchapter if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1395n(b) of this title furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) of this section and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1395cc(a) of this title.

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 426 of this title for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such

² So in original. Probably should be "1395ww(b)(3)(B)(ix)(III)".

form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1395e of this title, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1395x(v)(4) of this title), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

(e) Payment for inpatient hospital services prior to notification of noneligibility

Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1395d of this title and if such hospital complies with the requirements of and regulations under this subchapter with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

(f) Payment for certain inpatient hospital services furnished outside United States

(1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 426 of this title by a hospital located outside the United States, or under arrangements (as defined in section 1395x(w) of this title) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital

within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 426 of this title by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) of this section to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1395x(w) of this title) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this subchapter and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1395cc(a) of this title.

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 426 of this title may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1395e of this title, be equal to the amount which would be payable under subsection (d)(3) of this section.

(g) Payments to physicians for services rendered in teaching hospitals

For purposes of services for which the reasonable cost thereof is determined under section 1395x(v)(1)(D) of this title (or would be if section 1395ww of this title did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(1) such hospital has an agreement with the Secretary under section 1395cc of this title, and

(2) the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).

(h) Payment for specified hospital services provided in Department of Veterans Affairs hospitals; amount of payment

(1) Payments shall also be made to any hospital operated by the Department of Veterans Affairs for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital benefits under section 426 of this title even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this subchapter.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Secretary of Veterans Affairs for such services, or (if less) the amount that would be payable for such services under subsection (b) of this section and section 1395ww of this title (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

(i) Payment for hospice care

(1)(A) Subject to the limitation under paragraph (2) and the provisions of section 1395e(a)(4) of this title and except as otherwise provided in this paragraph, the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1395x(v)(1)(A) of this title), except that no payment may be made for bereavement coun-

seling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

(B) Notwithstanding subparagraph (A), for hospice care furnished on or after April 1, 1986, the daily rate of payment per day for routine home care shall be \$63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by \$10.

(C)(i) With respect to routine home care and other services included in hospice care furnished on or after January 1, 1990, and on or before September 30, 1990, the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year (before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by—

(I) for a fiscal year ending on or before September 30, 1993, the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year;

(II) for fiscal year 1994, the market basket percentage increase for the fiscal year minus 2.0 percentage points;

(III) for fiscal year 1995, the market basket percentage increase for the fiscal year minus 1.5 percentage points;

(IV) for fiscal year 1996, the market basket percentage increase for the fiscal year minus 1.5 percentage points;

(V) for fiscal year 1997, the market basket percentage increase for the fiscal year minus 0.5 percentage point;

(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points, plus, in the case of fiscal year 2001, 5.0 percentage points; and

(VII) for a subsequent fiscal year (before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clauses (iv) and (vi), the market basket percentage increase for the fiscal year.

(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clauses (iv) and (vi), the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year.

(iv) Subject to clause (vi), after determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and (II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.3 percentage point.

The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting “0.0 percentage points” for “0.3 percentage point”, if for such fiscal year—

(I) the excess (if any) of—

(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

(II) 5 percentage points.

(vi) For fiscal year 2018, the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, after application of clause (iv), shall be 1 percent.

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the “cap amount” for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

(B)(i) Except as provided in clause (ii), for purposes of subparagraph (A), the “cap amount” for a year is \$6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.

(ii) For purposes of subparagraph (A) for accounting years that end after September 30, 2016, and before October 1, 2025, the “cap amount” is the cap amount under this subparagraph for the preceding accounting year updated by the percentage update to payment rates for hospice care under paragraph (1)(C) for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year (including the application of any productivity or other adjustment under clause (iv) of that paragraph).

(iii) For accounting years that end after September 30, 2025, the cap amount shall be computed under clause (i) as if clause (ii) had never applied.

(C) For purposes of subparagraph (A), the “number of medicare beneficiaries” in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) of this section with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

(D) A hospice program shall submit claims for payment for hospice care furnished in an individual’s home under this subchapter only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

(3) Hospice programs providing hospice care for which payment is made under this subsection shall submit to the Secretary such data with respect to the costs for providing such care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines necessary.

(4) The amount paid to a hospice program with respect to the services under section 1395d(a)(5) of this title for which payment may be made under this part shall be equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decisionmaking of low complexity under the fee schedule established under section 1395w-4(b) of this title, other than the portion of such amount attributable to the practice expense component.

(5) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of clauses (iv) and (vi) of paragraph (1)(C), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each

hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.

(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

- (i) charges and payments;
- (ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under this part; and
- (iii) with respect to each type of service included in hospice care—
 - (I) the number of days of hospice care attributable to the type of service;
 - (II) the cost of the type of service; and
 - (III) the amount of payment for the type of service;
- (iv) charitable contributions and other revenue of the hospice program;
- (v) the number of hospice visits;
- (vi) the type of practitioner providing the visit; and
- (vii) the length of the visit and other basic information with respect to the visit.

(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this subchapter for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this subchapter for such care in such fiscal year if such revisions had not been implemented.

(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).

(7) In the case of hospice care provided by a hospice program under arrangements under section 1395x(dd)(5)(D) of this title made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

(j) Elimination of lesser-of-cost-or-charges provision

(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase in the amount of payments made for those services under this subchapter. Such change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this subchapter for services provided by that class of provider.

(2) The lesser-of-cost-or-charges provisions referred to in paragraph (1) are as follows:

(A) Clause (B) of paragraph (1) and paragraph (2) of subsection (b) of this section.

(B) Section 1395m(a)(1)(B) of this title.

(C) So much of subparagraph (A) of section 1395l(a)(2) of this title as provides for payment other than of the reasonable cost of such services, as determined under section 1395x(v) of this title.

(D) Subclause (II) of clause (i) and clause (ii) of section 1395l(a)(2)(B) of this title.

(k) Payments to home health agencies for durable medical equipment

The amount paid to any home health agency with respect to durable medical equipment for which payment may be made under this part shall be the amount described in section 1395m(a)(1) of this title.

(l) Payment for inpatient critical access hospital services

(1) Except as provided in the subsequent paragraphs of this subsection, the amount of payment under this part for inpatient critical access hospital services is equal to 101 percent of the reasonable costs of the critical access hospital in providing such services.

(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1395i-4(c)(2)(E) of this title, the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title.

(3)(A) The following rules shall apply in determining payment and reasonable costs under paragraph (1) for costs described in subparagraph (C) for a critical access hospital that would be a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title) for an EHR reporting period for a cost reporting period beginning during a payment year if such critical access hospital was treated as an eligible hospital under such section:

(i) The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved).

(ii) There shall be substituted for the Medicare share that would otherwise be applied under paragraph (1) a percent (not to exceed 100 percent) equal to the sum of—

(I) the Medicare share (as would be specified under paragraph (2)(D) of section 1395ww(n) of this title) for such critical access hospital if such critical access hospital was treated as an eligible hospital under such section; and

(II) 20 percentage points.

(B) The payment under this paragraph with respect to a critical access hospital shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment, including information necessary to apply this paragraph. In no case may payment under this paragraph be made with respect to a cost reporting period beginning during a payment year after 2015 and in no case may a critical access hospital receive payment under this paragraph with respect to more than 4 consecutive payment years.

(C) The costs described in this subparagraph are costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph.

(D) For purposes of this paragraph, paragraph (4), and paragraph (5), the terms “certified EHR technology”, “eligible hospital”, “EHR reporting period”, and “payment year” have the meanings given such terms in sections 1395ww(n) of this title.

(4)(A) Subject to subparagraph (C), for cost reporting periods beginning in fiscal year 2015 or a subsequent fiscal year, in the case of a critical access hospital that is not a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title if such critical access hospital was treated as an eligible hospital under such section) for an EHR reporting period with respect to such fiscal year, paragraph (1) shall be applied by substituting the applicable percent under subparagraph (B) for the percent described in such paragraph (1).

(B) The percent described in this subparagraph is—

- (i) for fiscal year 2015, 100.66 percent;
- (ii) for fiscal year 2016, 100.33 percent; and
- (iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent.

(C) The provisions of subclause (II) of section 1395ww(b)(3)(B)(ix) of this title shall apply with respect to subparagraph (A) for a critical access hospital with respect to a cost reporting period beginning in a fiscal year in the same manner as such subclause applies with respect to subclause (I) of such section for a subsection (d) hospital with respect to such fiscal year.

(5) There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(A) the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1395ww(n)(2) of this title for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1395ww(n)(2) of this title;

(B) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title as would apply if the hospital was treated as an eligible hospital under section 1395ww(n) of this title, and the hardship exception under paragraph (4)(C);

(C) the specification of EHR reporting periods under section 1395ww(n)(6)(B)³ of this title as applied under paragraphs (3) and (4); and

(D) the identification of costs for purposes of paragraph (3)(C).

(Aug. 14, 1935, ch. 531, title XVIII, § 1814, as added Pub. L. 89-87, title I, § 102(a), July 30, 1965, 79 Stat. 294; amended Pub. L. 90-248, title I, §§ 126(a), 129(c)(5), (6)(A), 143(c), Jan. 2, 1968, 81 Stat. 846, 848, 857; Pub. L. 92-603, title II, §§ 211(a), 226(c)(1), 227(b), 228(a), 233(a), 234(g)(1), 238(a),

³ So in original. Probably should be “1395ww(n)(3)(B)”.

247(a), 256(a), 278(a)(1)–(3), (b)(4), (17), 281(e), Oct. 30, 1972, 86 Stat. 1382, 1404, 1405, 1407, 1411, 1413, 1416, 1425, 1447, 1453, 1454, 1456; Pub. L. 93–233, § 18(k)(1), (2), Dec. 31, 1973, 87 Stat. 970; Pub. L. 94–437, title IV, § 401(a), Sept. 30, 1976, 90 Stat. 1408; Pub. L. 95–142, § 23(a), (b), Oct. 25, 1977, 91 Stat. 1208; Pub. L. 95–292, § 4(f), June 13, 1978, 92 Stat. 315; Pub. L. 96–499, title IX, §§ 903(a), 930(e), (f), 931(b), 936(b), 941(a), (b), Dec. 5, 1980, 94 Stat. 2614, 2631, 2633, 2640, 2641; Pub. L. 97–35, title XXI, §§ 2121(b), 2122(a)(1), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97–248, title I, §§ 101(c)(1), 122(c)(1), (2), Sept. 3, 1982, 96 Stat. 335, 357, 358; Pub. L. 97–448, title III, § 309(b)(7), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§ 601(d), 602(b), (c), Apr. 20, 1983, 97 Stat. 152, 163; Pub. L. 98–90, Aug. 29, 1983, 97 Stat. 606; Pub. L. 98–369, div. B, title III, §§ 2308(b)(2)(A), 2321(a), (f), 2335(a), 2336(a), (b), 2354(b)(1), (c)(1)(A), July 18, 1984, 98 Stat. 1074, 1084, 1085, 1090, 1091, 1100, 1102; Pub. L. 98–617, § 1(a), 3(a)(3), (b)(1), Nov. 8, 1984, 98 Stat. 3294, 3295; Pub. L. 99–272, title IX, § 9123(b), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100–203, title IV, §§ 4008(b)(1), 4024(a), 4062(d)(1), Dec. 22, 1987, 101 Stat. 1330–55, 1330–73, 1330–108; Pub. L. 100–360, title I, § 104(d)(2), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–239, title VI, §§ 6003(g)(3)(B)(ii), (iii), 6005(a), (b), 6028, Dec. 19, 1989, 103 Stat. 2152, 2160, 2161, 2168; Pub. L. 101–508, title IV, §§ 4006(b), 4008(i)(3), (m)(3)(A), Nov. 5, 1990, 104 Stat. 1388–43, 1388–51, 1388–53; Pub. L. 102–54, § 13(q)(3)(A)(iii), (iv), (B)(iv), June 13, 1991, 105 Stat. 279; Pub. L. 103–66, title XIII, § 13504, Aug. 10, 1993, 107 Stat. 579; Pub. L. 103–432, title I, §§ 102(a)(3), (d), 106(b)(1)(A), 110(d)(1), Oct. 31, 1994, 108 Stat. 4402, 4403, 4405, 4408; Pub. L. 105–33, title IV, §§ 4201(c)(1), (3), 4441, 4442(a), 4443(b)(2), 4448, 4603(c)(1), 4615(a), Aug. 5, 1997, 111 Stat. 373, 422–424, 470, 475; Pub. L. 106–554, § 1(a)(6) [title III, §§ 321(a), (e), 322(a)(1), title V, § 507(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, 2763A–501, 2763A–532; Pub. L. 108–173, title IV, §§ 405(a)(1), (g)(2), 408(b), title V, § 512(b), title VII, § 736(a)(1), (2), (c)(2)(A), title IX, § 946(b), Dec. 8, 2003, 117 Stat. 2266, 2269, 2270, 2299, 2354, 2356, 2425; Pub. L. 111–5, div. B, title IV, § 4102(a)(2), (b)(2), (d)(1), Feb. 17, 2009, 123 Stat. 481, 483, 486; Pub. L. 111–148, title III, §§ 3004(c), 3108(a), 3132, 3401(g), title VI, §§ 6404(a)(1), 6405(b)(1), 6407(a)(1), title X, §§ 10319(f), 10604, 10605(a), Mar. 23, 2010, 124 Stat. 370, 418, 430, 484, 767–769, 949, 1006; Pub. L. 113–185, § 3(c), (d), Oct. 6, 2014, 128 Stat. 1969; Pub. L. 114–10, title IV, § 411(d), Apr. 16, 2015, 129 Stat. 161.)

REFERENCES IN TEXT

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b)(3), means section 402 of Pub. L. 90–248, which amended sections 1395b–1 and 1395f of this title.

Section 222 of the Social Security Amendments of 1972, referred to in subsec. (b)(3), means section 222 of Pub. L. 92–603, which amended sections 1395b–1 and 1395f of this title and enacted a provision set out as a note under section 1395b–1 of this title.

The Patient Protection and Affordable Care Act, referred to in subsec. (i)(1)(C)(v)(I)(aa), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. The Act's final passage, clearing it for enrollment, occurred in the House of Representatives on Mar. 21, 2010. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

AMENDMENTS

2015—Subsec. (i)(1)(C)(ii)(VII). Pub. L. 114–10, § 411(d)(1)(A), substituted “clauses (iv) and (vi),” for “clause (iv),”.

Subsec. (i)(1)(C)(iii). Pub. L. 114–10, § 411(d)(1)(B), substituted “clauses (iv) and (vi),” for “clause (iv),”.

Subsec. (i)(1)(C)(iv). Pub. L. 114–10, § 411(d)(1)(C), substituted “Subject to clause (vi), after determining” for “After determining” in introductory provisions.

Subsec. (i)(1)(C)(vi). Pub. L. 114–10, § 411(d)(1)(D), added cl. (vi).

Subsec. (i)(5)(A)(i). Pub. L. 114–10, § 411(d)(2), substituted “clauses (iv) and (vi) of paragraph (1)(C)” for “paragraph (1)(C)(iv)”.

2014—Subsec. (a)(7)(D). Pub. L. 113–185, § 3(c)(2), inserted “(and, in the case of clause (ii), before October 6, 2014)” after “2011” in introductory provisions.

Subsec. (a)(7)(E). Pub. L. 113–185, § 3(c)(1), (3), added subpar. (E).

Subsec. (i)(2)(B). Pub. L. 113–185, § 3(d), substituted “(B)(i) Except as provided in clause (ii), for purposes” for “(B) For purposes” and added cls. (ii) and (iii).

2010—Subsec. (a). Pub. L. 111–148, § 6404(a)(1)(B), inserted at end of concluding provisions “In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.”

Pub. L. 111–148, § 3108(a)(2), substituted “clinical nurse specialist, or physician assistant” for “or clinical nurse specialist” in concluding provisions.

Subsec. (a)(1). Pub. L. 111–148, § 6404(a)(1)(A), substituted “period ending 1 calendar year after the date of service;” for “period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;”.

Subsec. (a)(2). Pub. L. 111–148, § 6405(b)(1), as amended by Pub. L. 111–148, § 10604, inserted “, or, in the case of services described in subparagraph (C), a physician enrolled under section 1395cc(j) of this title,” after “in collaboration with a physician,” in introductory provisions.

Pub. L. 111–148, § 3108(a)(1), substituted “, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1395x(aa)(5) of this title)” for “or clinical nurse specialist” in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 111–148, § 10605(a), inserted “, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician,” after “himself or herself”.

Pub. L. 111–148, § 6407(a)(1), substituted “such services are or were furnished” for “and such services are or were furnished” and inserted “, and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1395m(m) of this title, and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary” after “care of a physician”.

Subsec. (a)(7)(D). Pub. L. 111–148, § 3132(b), added subpar. (D).

Subsec. (i)(1)(C)(ii). Pub. L. 111–148, § 3132(a)(2)(A)(i), inserted “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)” after “subsequent fiscal year” in introductory provisions.

Subsec. (i)(1)(C)(ii)(VII). Pub. L. 111-148, §3132(a)(2)(A)(ii), inserted “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv),” after “subsequent fiscal year”.

Subsec. (i)(1)(C)(iii). Pub. L. 111-148, §3132(a)(2)(B), added cl. (iii).

Subsec. (i)(1)(C)(iv). Pub. L. 111-148, §3401(g), added cl. (iv).

Subsec. (i)(1)(C)(iv)(II). Pub. L. 111-148, §10319(f)(1), substituted “0.3” for “0.5”.

Subsec. (i)(1)(C)(v). Pub. L. 111-148, §10319(f)(2), substituted “0.3” for “0.5” in introductory provisions.

Pub. L. 111-148, §3401(g), added cl. (v).

Subsec. (i)(5). Pub. L. 111-148, §3004(c)(2), added par. (5). Former par. (5) redesignated (6).

Subsec. (i)(6). Pub. L. 111-148, §3132(a)(1)(B), added par. (6). Former par. (6) redesignated (7).

Pub. L. 111-148, §3004(c)(1), redesignated par. (5) as (6).

Subsec. (i)(7). Pub. L. 111-148, §3132(a)(1)(A), redesignated par. (6) as (7).

2009—Subsec. (b). Pub. L. 111-5, §4102(d)(1)(B), inserted at end of concluding provisions “For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1395ww of this title.”

Subsec. (b)(3). Pub. L. 111-5, §4102(d)(1)(A), inserted “, subject to section 1395ww(d)(3)(B)(ix)(III) of this title,” before “the Secretary may provide” in introductory provisions.

Subsec. (l)(1). Pub. L. 111-5, §4102(a)(2)(A), substituted “the subsequent paragraphs of this subsection” for “paragraph (2)”.

Subsec. (l)(3) to (5). Pub. L. 111-5, §4102(a)(2)(B), (b)(2), added pars. (3) to (5).

2003—Subsec. (a). Pub. L. 108-173, §736(a)(1)(A), (c)(2)(A), in concluding provisions, substituted “leave home and” for “leave home,” in sixth sentence and struck out “The certification regarding terminal illness of an individual under paragraph (7) shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.” after “taxing effort by the individual.”

Subsec. (a)(7)(A)(i). Pub. L. 108-173, §736(a)(1)(B)(i), inserted “based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness” before “, and” in concluding provisions.

Subsec. (a)(7)(A)(i)(I). Pub. L. 108-173, §408(b), inserted “(which for purposes of this subparagraph does not include a nurse practitioner)” after “attending physician (as defined in section 1395x(dd)(3)(B) of this title)”.

Subsec. (a)(7)(A)(ii). Pub. L. 108-173, §736(a)(1)(B)(ii), inserted “based on such clinical judgment” before semicolon at end.

Subsec. (b). Pub. L. 108-173, §736(a)(2), inserted comma after “1395e” in introductory provisions.

Subsec. (i)(4). Pub. L. 108-173, §512(b), added par. (4).

Subsec. (i)(5). Pub. L. 108-173, §946(b), added par. (5).

Subsec. (l). Pub. L. 108-173, §405(g)(2), designated existing provisions as par. (1), substituted “Except as provided in paragraph (2), the amount” for “The amount”, and added par. (2).

Pub. L. 108-173, §405(a)(1), inserted “equal to 101 percent of” before “the reasonable costs”.

2000—Subsec. (a). Pub. L. 106-554, §1(a)(6) [title V, §507(a)(1)(B)], inserted at end “Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psycho-social, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be ‘confined to his home’. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious

service shall be deemed to be an absence of infrequent or short duration.”

Pub. L. 106-554, §1(a)(6) [title V, §507(a)(1)(A)], which directed amendment of subsec. (a) by striking out in the last sentence “, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment”, was executed by striking out that language after “taxing effort by the individual” in the penultimate sentence, to reflect the probable intent of Congress and the amendment by Pub. L. 106-554, §1(a)(6) [title III, §322(a)(1)]. See note below.

Pub. L. 106-554, §1(a)(6) [title III, §322(a)(1)], inserted at end “The certification regarding terminal illness of an individual under paragraph (7) shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.”

Subsec. (a)(7)(A)(ii). Pub. L. 106-554, §1(a)(6) [title III, §321(e)], substituted a semicolon for period at end.

Subsec. (i)(1)(C)(ii)(VI). Pub. L. 106-554, §1(a)(6) [title III, §321(a)], inserted “, plus, in the case of fiscal year 2001, 5.0 percentage points” before semicolon.

1997—Subsec. (a)(2)(C). Pub. L. 105-33, §4615(a), inserted “(other than solely venipuncture for the purpose of obtaining a blood sample)” after “skilled nursing care”.

Subsec. (a)(7)(A)(i). Pub. L. 105-33, §§4443(b)(2)(A), 4448, in concluding provisions, substituted “at the beginning of the period” for “not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)” and inserted “and” at end.

Subsec. (a)(7)(A)(ii). Pub. L. 105-33, §4443(b)(2)(B), substituted “60-day” for “30-day” and substituted a period for “, and” at end.

Subsec. (a)(7)(A)(iii). Pub. L. 105-33, §4443(b)(2)(C), struck out cl. (iii) which read as follows: “in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;”.

Subsec. (a)(8). Pub. L. 105-33, §4201(c)(1), (3)(A), substituted “critical access” for “rural primary care” in two places and “96 hours” for “72 hours”.

Subsec. (b). Pub. L. 105-33, §4603(c)(1), substituted “1395ww, and 1395fff of this title” for “and 1395ww of this title” in introductory provisions.

Pub. L. 105-33, §4201(c)(1), substituted “critical access” for “rural primary care” in two places in introductory provisions.

Subsec. (i)(1)(C)(ii)(V) to (VII). Pub. L. 105-33, §4441(a), struck out “and” at end of subcl. (V), added subcl. (VI), and redesignated former subcl. (VI) as (VII).

Subsec. (i)(2)(D). Pub. L. 105-33, §4442(a), added subpar. (D).

Subsec. (i)(3). Pub. L. 105-33, §4441(b), added par. (3).

Subsec. (l). Pub. L. 105-33, §4201(c)(3)(B), amended heading and text of subsec. (l) generally. Prior to amendment, text read as follows:

“(1) The amount of payment under this part for inpatient rural primary care hospital services—

“(A) in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and

“(B) in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1395ww(b)(3)(B)(i) of this title for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1395i-4(a)(2) of this title (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover

the provision of inpatient rural primary care hospital services.

“(2) The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1996.”

1994—Subsec. (a)(5). Pub. L. 103-432, §106(b)(1)(A), struck out “and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations” after “continuous period of such services”, “or skilled nursing facility, as the case may be” after “such individual to the hospital”, and “or facility” after “made in such hospital”.

Subsec. (a)(8). Pub. L. 103-432, §102(a)(3), substituted “the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.” for “such services were required to be immediately furnished on a temporary, inpatient basis.”

Subsec. (i)(1)(C)(i). Pub. L. 103-432, §110(d)(1), substituted “September 30, 1990,” for “September 30, 1990.”.

Subsec. (l)(2). Pub. L. 103-432, §102(d), substituted “January 1, 1996” for “January 1, 1993”.

1993—Subsec. (i)(1)(C)(ii). Pub. L. 103-66 substituted “increased by—” and subcls. (I) to (VI) for “increased by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) otherwise applicable to discharges occurring in the fiscal year.”

1991—Subsec. (h). Pub. L. 102-54 substituted “Department of Veterans Affairs” for “Veterans’ Administration” in heading and par. (1) and “Secretary of Veterans Affairs” for “Veterans’ Administration” in par. (2).

1990—Subsec. (a)(7)(A)(iii). Pub. L. 101-508, §4006(b), added cl. (iii).

Subsec. (b)(3). Pub. L. 101-508, §4008(i)(3), substituted “January 1, 1981” for “October 1, 1983” in subpar. (B) substituted “37th month” for “seventh month” in sentence following subpar. (B), and inserted at end provisions setting forth procedures to be followed by Secretary at end of 36-month period.

Subsec. (i)(1)(C)(i). Pub. L. 101-508, §4008(m)(3)(A), substituted “on or after January 1, 1990, and on or before September 30, 1990,” for “during fiscal year 1990”.

1989—Subsec. (a). Pub. L. 101-239, §6028(2), substituted “a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes” for “a physician makes” in first sentence of concluding provisions.

Subsec. (a)(2). Pub. L. 101-239, §6028(1), substituted “a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,” for “a physician” after “(2)”.

Subsec. (a)(2)(B), (6). Pub. L. 101-234 repealed Pub. L. 100-360, §104(d)(2)(A), (B), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(7)(A)(i). Pub. L. 101-239, §6005(b), substituted “certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated),” for “certify, not later than two days after hospice care is initiated,” in concluding provisions.

Subsec. (a)(7)(A)(iii). Pub. L. 101-234 repealed Pub. L. 100-360, §104(d)(2)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(8). Pub. L. 101-239, §6003(g)(3)(B)(ii), added par. (8).

Subsec. (b). Pub. L. 101-239, §6003(g)(3)(B)(iii)(I), inserted “, other than a rural primary care hospital providing inpatient rural primary care hospital services,” after “providing hospice care” in introductory provisions.

Subsec. (d)(3). Pub. L. 101-234 repealed Pub. L. 100-360, §104(d)(2)(D), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (i)(1)(A). Pub. L. 101-239, §6005(a)(1), inserted “and except as otherwise provided in this paragraph” after “section 1395e(a)(4) of this title”.

Subsec. (i)(1)(C). Pub. L. 101-239, §6005(a)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: “With respect to care and services furnished on or after October 1, 1986, the Secretary shall, not less often than annually, review and make appropriate adjustments to the payment rate for routine home care and the payment rates for other services included in hospice care based on the costs that are reasonable and related to the costs of furnishing such care and services. The Secretary shall report to Congress on October 1 each year on such review and such adjustments and on the adequacy of the rates under this paragraph to ensure participation by an adequate number of hospice programs under this subchapter.”

Subsec. (l). Pub. L. 101-239, §6003(g)(3)(B)(iii)(II), added subsec. (l).

1988—Subsec. (a)(2)(B). Pub. L. 100-360, §104(d)(2)(A), (B), struck out “post-hospital” after “in the case of” and “, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1395x(e) of this title) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services” before semicolon at end.

Subsec. (a)(6). Pub. L. 100-360, §104(d)(2)(A), struck out “post-hospital” before “extended care services” in two places.

Subsec. (a)(7)(A)(iii). Pub. L. 100-360, §104(d)(2)(C), added cl. (iii) which read as follows: “in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;”

Subsec. (d)(3). Pub. L. 100-360, §104(d)(2)(D), substituted “equal to 100 percent” for “equal to 60 percent” and “plus 100 percent” for “plus 80 percent” and struck out “two-thirds of” after “based on”.

1987—Subsec. (a). Pub. L. 100-203, §4024(a), inserted two sentences at end clarifying “confined to his home” for purposes of par. (2)(C).

Subsec. (b)(3)(B). Pub. L. 100-203, §4008(b)(1), substituted “aggregate rate of increase from October 1, 1983, to the most recent date for which annual data are available” for “rate of increase for the previous three-year period”.

Subsec. (j)(2)(B). Pub. L. 100-203, §4062(d)(1)(A), substituted “Section 1395m(a)(1)(B) of this title” for “Subsection (k)(1)(B) of this section”.

Subsec. (k). Pub. L. 100-203, §4062(d)(1)(B), substituted “the amount described in section 1395m(a)(1) of this title.” for a dash and former pars. (1) and (2) which read as follows:

“(1) the lesser of—

“(A) the reasonable cost of such equipment, as determined under section 1395x(v) of this title, or

“(B) the customary charges with respect to such equipment,

less the amount the home health agency may charge as described in section 1395cc(a)(2)(A)(ii) of this title, but in no case may the payment for such equipment exceed 80 percent of such reasonable cost, or

“(2) if such equipment is furnished by a public home health agency, or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charge to the public, 80 percent of the amount which the Secretary

finds will provide fair compensation to the home health agency.”

1986—Subsec. (i)(1)(B). Pub. L. 99-272, §9123(b)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “Notwithstanding subparagraph (A), the rate of payment per day for routine home care furnished during fiscal year 1985 shall be \$53.17.”

Subsec. (i)(1)(C). Pub. L. 99-272, §9123(b)(2), substituted “1986” for “1985”.

1984—Subsec. (a). Pub. L. 98-369, §2354(b)(1), as amended by Pub. L. 98-617, §3(a)(3), in concluding provisions, substituted “contractual” for “contractural”.

Pub. L. 98-369, §2336(b), inserted before period at end of third sentence “, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary)”.

Pub. L. 98-369, §2336(a), inserted sentence at end that for purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency.

Pub. L. 98-369, §2335(a)(4), in concluding provisions, substituted “or (D)” for “(D), or (E)”.

Subsec. (a)(2)(B) to (E). Pub. L. 98-369, §2335(a)(1), redesignated subpars. (C) to (E) as (B) to (D), respectively, and struck out former subpar. (B) which provided that payment could be made only if a physician certified, in the case of inpatient tuberculosis hospital services, that such services were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and that such treatment could reasonably be expected to improve the condition for which such treatment was necessary or render the condition non-communicable.

Subsec. (a)(3). Pub. L. 98-369, §2335(a)(2), struck out “and inpatient tuberculosis hospital services” after “psychiatric hospital services”.

Subsec. (a)(5) to (8). Pub. L. 98-369, §2335(a)(3), redesignated pars. (6) to (8) as (5) to (7), respectively, and struck out former par. (5) which had provided that payment would be made only if, in the case of inpatient tuberculosis hospital services, the services were those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

Subsec. (b). Pub. L. 98-369, §2321(a)(1), inserted in provisions preceding par. (1) “and other than a home health agency with respect to durable medical equipment” after “hospice care”.

Subsec. (b)(2). Pub. L. 98-369, §2308(b)(2)(A), inserted “, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph).”

Subsec. (b)(3). Pub. L. 98-369, §2354(c)(1)(A), amended directory language of Pub. L. 96-449, §903(a)(4), resulting in no change in text. See 1980 Amendment note below.

Subsec. (i)(1). Pub. L. 98-617, §1(a), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j)(2)(B) to (D). Pub. L. 98-369, §2321(f), added subpar. (B) and redesignated former subpars. (B) and (C) as (C) and (D), respectively.

Subsec. (k). Pub. L. 98-369, §2321(a)(2), added subsec. (k).

Subsec. (k)(2). Pub. L. 98-617, §3(b)(1), inserted “, or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph),” after “public home health agency” and “80 percent of” before “the amount”.

1983—Subsec. (g). Pub. L. 98-21, §602(b), inserted “(or would be if section 1395ww of this title did not apply)” after “section 1395x(v)(1)(D) of this title”.

Subsec. (h)(2). Pub. L. 98-21, §602(c), substituted “the amount that would be payable for such services under subsection (b) of this section and section 1395ww of this title” for “the reasonable costs for such services”.

Subsec. (i)(1). Pub. L. 97-448 inserted “made” before “for bereavement counseling”.

Subsec. (i)(2)(A). Pub. L. 98-90, §1(1), struck out “located in a region (as defined by the Secretary)” after “a hospice program” and “for the region” after “the cap amount”.

Subsec. (i)(2)(B). Pub. L. 98-90, §1(2), amended subpar. (B) generally, substituting provisions establishing a hospice reimbursement cap amount of \$6,500, indexed by the medical care component of the Consumer Price Index, for provisions which had established a cap of 40% of the estimated regional average medicare expenditure per beneficiary in the regular medicare program during the six months of life for persons dying of cancer.

Subsec. (j). Pub. L. 98-21, §601(d)(2), added subsec. (j) by transferring and redesignating provisions formerly classified to subsec. (d) of section 1395ww of this title.

Subsec. (j)(2)(A). Pub. L. 98-21, §601(d)(1), substituted “subsection (b) of this section” for “section 1395f(b) of this title”.

1982—Subsec. (a)(8). Pub. L. 97-248, §122(c)(1), added par. (8).

Subsec. (b). Pub. L. 97-248, §101(c)(1), substituted “sections 1395e and 1395ww” for “section 1395e” in provisions preceding par. (1), and substituted “until the first day of the seventh month beginning after the date the Secretary determines and notifies the Governor of the State” for “until the Secretary determines” in provisions following par. (3).

Pub. L. 97-248, §122(c)(2)(A), inserted “(other than a hospice program providing hospice care)” after “The amount paid to any provider of services”.

Subsec. (i). Pub. L. 97-248, §122(c)(2)(B), added subsec. (i).

1981—Subsec. (a)(2)(D). Pub. L. 97-35, §2122(a)(1), substituted “needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy” for “needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy”.

Subsec. (a)(2)(F). Pub. L. 97-35, §2121(b), struck out subpar. (F) which provided that in the case of alcohol detoxification facility services, such services were required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification).

1980—Subsec. (a). Pub. L. 96-499, §930(e), inserted provision at end of subsec. (a) authorizing the Secretary to prescribe regulations to prohibit significantly interested physicians from performing the physician certification required by par. (2) for home health services.

Subsec. (a)(2)(D). Pub. L. 96-499, §930(f), substituted “home health services” for “post-hospital home health services” and “physical, occupational, or speech” for “physical or speech” and deleted “, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1395x(e) of this title) or post-hospital extended care services” after “therapy”.

Subsec. (a)(2)(E). Pub. L. 96-499, §936(b), inserted “or because of the severity of the dental procedure” and substituted “such services” for “such dental services”.

Subsec. (a)(2)(F). Pub. L. 96-499, §931(b), added subpar. (F).

Subsec. (b)(1). Pub. L. 96-499, §903(a)(1), inserted “except as provided in paragraph (3).”.

Subsec. (b)(3). Pub. L. 96-499, §903(a)(4), as amended by Pub. L. 98-369, §2354(c)(1)(A), added par. (3).

Subsec. (c). Pub. L. 96-499, §941(b), substituted “subsection (h)” for “subsection (j)”.

Subsecs. (h) to (j). Pub. L. 96-499, §941(a), struck out subsecs. (h) and (i) and redesignated subsec. (j) as (h).

1978—Subsec. (b)(1). Pub. L. 95-292 inserted “and as further limited by section 1395rr(b)(2)(B) of this title” after “section 1395x(v) of this title”.

1977—Subsec. (c). Pub. L. 95-142, §23(a), inserted reference to subsec. (j) of this section.

Subsec. (j). Pub. L. 95-142, §23(b), added subsec. (j).

1976—Subsec. (c). Pub. L. 94-437 substituted “Subject to section 1395qq of this title, no payment” for “No payment”.

1973—Subsec. (a)(2)(E). Pub. L. 93-233, §18(k)(1), substituted “the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status, requires hospitalization in connection with the provision of such dental services” for “a dental procedure, the individual suffers from impairments of such severity as to require hospitalization”.

Subsec. (a), last sentence. Pub. L. 93-233, §18(k)(2), inserted reference to subpar. (E) of par. (2).

1972—Subsec. (a). Pub. L. 92-603, §§226(c)(1), 227(b)(1), inserted reference to subsec. (g) of this section and section 1395mm of this title in provisions preceding par. (1).

Subsec. (a)(1). Pub. L. 92-603, §281(e), placed a 3-year time limitation on the time within which a written request for payment is filed, with provision for reduction of the limit to 1 year.

Subsec. (a)(2)(C). Pub. L. 92-603, §§234(g)(1), 247(a), 278(a)(1), substituted “because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis,” for “on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis”, “skilled nursing facility” for “extended care facility”, and “paragraphs (6) and (9) of section 1395x(e) of this title” for “paragraphs (6) and (8) of section 1395x(e) of this title”.

Subsec. (a)(2)(D). Pub. L. 92-603, §234(g)(1), substituted reference to par. (9) of section 1395x(e) of this title for reference to par. (8) of section 1395x(e) of this title.

Subsec. (a)(2)(E). Pub. L. 92-603, §256(a), added subpar. (E).

Subsec. (a)(6). Pub. L. 92-603, §278(a)(2), substituted “skilled nursing facility” for “extended care facility”.

Subsec. (a)(7). Pub. L. 92-603, §§238(a), 278(a)(3), inserted “, including any finding made in the course of a sample or other review of admissions to the institution” after “as described in section 1395x(k)(4) of this title” in the parenthetical provisions covering the finding not made by the committee or group, and substituted “skilled nursing facility” for “extended care facility”.

Subsec. (b). Pub. L. 92-603, §233(a), substituted pars. (1) and (2) for provisions describing the amount payable as the reasonable cost determined under section 1395x(v) of this title.

Subsec. (f). Pub. L. 92-603, §211(a), designated existing provisions as par. (2), added pars. (1) and (3), and in par. (2) as so redesignated inserted provisions covering individuals physically present at a place within Canada while traveling without unreasonable delay by the most direct route between Alaska and another State.

Subsec. (g). Pub. L. 92-603, §227(b)(2), added subsec. (g).

Subsec. (h). Pub. L. 92-603, §§228(a), 278(b)(4), (17), added subsec. (h) and substituted “skilled nursing facility” for “extended care facility”.

Subsec. (i). Pub. L. 92-603, §228(a), added subsec. (i).

1968—Subsec. (a). Pub. L. 90-248, §§126(a)(5), 129(c)(5)(B), struck out references to former subpars. (E) and (F) in last sentence.

Subsec. (a)(2)(A) to (E). Pub. L. 90-248, §126(a)(1), (2), struck out subpar. (A) which provided that there be a physician's certification of medical necessity for admissions to hospitals other than psychiatric or tuber-

culosis institutions, and redesignated subpars. (B) to (E) as (A) to (D), respectively.

Subsec. (a)(2)(F). Pub. L. 90-248, §129(c)(5)(A), struck out subpar. (F) which provided that there be a physician's certification for services furnished to outpatients.

Subsec. (a)(3) to (7). Pub. L. 90-248, §126(a)(3), (4), added par. (3) and redesignated former pars. (3) to (6) as (4) to (7), respectively.

Subsec. (d). Pub. L. 90-248, §129(c)(6)(A), struck out reference to outpatient hospital diagnostic services from provisions requiring payment for emergency hospital services.

Subsec. (d)(1) to (3). Pub. L. 90-248, §143(c), designated existing provisions as par. (1), inserted “in a calendar year” after “furnished” in first sentence of par. (1), added subpar. (C) to par. (1), and added pars. (2) and (3).

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title III, §3108(b), Mar. 23, 2010, 124 Stat. 418, provided that: “The amendments made by this section [amending this section] shall apply to items and services furnished on or after January 1, 2011.”

Pub. L. 111-148, title VI, §6404(b), Mar. 23, 2010, 124 Stat. 768, provided that:

“(1) IN GENERAL.—The amendments made by subsection (a) [amending this section and sections 1395n and 1395u of this title] shall apply to services furnished on or after January 1, 2010.

“(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) [probably means section 1814(a)(1) (42 U.S.C. 1395f(a)(1)), 1842(b)(3)(B) (42 U.S.C. 1395u(b)(3)(B)), or 1835(a) (42 U.S.C. 1395n(a)) of act Aug. 14, 1935] shall be filed not later than [sic] December 31, 2010.”

Pub. L. 111-148, title VI, §6405(d), Mar. 23, 2010, 124 Stat. 769, provided that: “The amendments made by this section [amending this section and sections 1395m and 1395n of this title] shall apply to written orders and certifications made on or after July 1, 2010.”

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title IV, §405(a)(2), Dec. 8, 2003, 117 Stat. 2266, provided that: “The amendments made by paragraph (1) [amending this section and sections 1395m and 1395tt of this title] shall apply to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.”

Pub. L. 108-173, title IV, §405(g)(3), Dec. 8, 2003, 117 Stat. 2269, provided that: “The amendments made by this subsection [amending this section and section 1395i-4 of this title] shall apply to cost reporting periods beginning on or after October 1, 2004.”

Amendment by section 512(b) of Pub. L. 108-173 applicable to services provided by a hospice program on or after Jan. 1, 2005, see section 512(d) of Pub. L. 108-173, set out as a note under section 1395d of this title.

Pub. L. 108-173, title IX, §946(c), Dec. 8, 2003, 117 Stat. 2425, provided that: “The amendments made by this section [amending this section and section 1395x of this title] shall apply to hospice care provided on or after the date of the enactment of this Act [Dec. 8, 2003].”

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, §1(a)(6) [title III, §321(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-500, provided that: “The amendment made by subsection (a) [amending this section] shall apply to hospice care furnished on or after April 1, 2001. In applying clause (ii) of section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) beginning with fiscal year 2002, the payment rates in effect under such section during the period beginning on April 1, 2001, and ending on September 30, shall be treated as the payment rates in effect during fiscal year 2001.”

Pub. L. 106-554, §1(a)(6) [title III, §322(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-501, provided that: “The

amendment made by paragraph (1) [amending this section] shall apply to certifications made on or after the date of the enactment of this Act [Dec. 21, 2000].”

Pub. L. 106-554, §1(a)(6) [title V, §507(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-532, provided that: “The amendments made by paragraph (1) [amending this section and section 1395n of this title] shall apply to home health services furnished on or after the date of the enactment of this Act [Dec. 21, 2000].”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-33, title IV, §4201(d), Aug. 5, 1997, 111 Stat. 374, provided that: “The amendments made by this section [amending this section and sections 1320a-7a, 1320a-7b, 1320b-4, 1320b-8, 1395d, 1395e, 1395h, 1395i-4, 1395k to 1395n, 1395u, 1395x, 1395y, 1395aa, 1395cc, 1395dd, and 1395ww of this title] shall apply to services furnished on or after October 1, 1997.”

Pub. L. 105-33, title IV, §4442(b), Aug. 5, 1997, 111 Stat. 423, as amended by Pub. L. 106-113, div. B, §1000(a)(6) [title III, §321(i)], Nov. 29, 1999, 113 Stat. 1536, 1501A-366, provided that: “The amendment made by subsection (a) [amending this section] applies to items and services furnished on or after October 1, 1997.”

Amendment by sections 4441, 4443(b)(2), and 4448 of Pub. L. 105-33 applicable to benefits provided on or after Aug. 5, 1997, except as otherwise provided, see section 4449 of Pub. L. 105-33, set out as a note under section 1395d of this title.

Amendment by section 4603(c)(1) of Pub. L. 105-33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105-33, set out as an Effective Date note under section 1395fff of this title.

Pub. L. 105-33, title IV, §4615(b), Aug. 5, 1997, 111 Stat. 475, provided that: “The amendments made by subsection (a) [amending this section and section 1395n of this title] apply to home health services furnished after the 6-month period beginning after the date of enactment of this Act [Aug. 5, 1997].”

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 106(b)(1)(A) of Pub. L. 103-432 effective as if included in the enactment of Pub. L. 100-203, see section 106(b)(2) of Pub. L. 103-432, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4006(b) of Pub. L. 101-508 applicable with respect to care and services furnished on or after Jan. 1, 1990, see section 4006(c) of Pub. L. 101-508, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-239, title VI, §6005(c), Dec. 19, 1989, 103 Stat. 2161, as amended by Pub. L. 101-508, title IV, §4008(m)(3)(B), Nov. 5, 1990, 104 Stat. 1388-54, provided that: “The amendments made by subsections (a) and (b) [amending this section] shall become effective with respect to care and services furnished on or after January 1, 1990.”

Amendment by Pub. L. 101-234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101-234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100-360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100-360, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100-203, title IV, §4008(b)(2), Dec. 22, 1987, 101 Stat. 1330-55, provided that: “The amendment made by

paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].”

Pub. L. 100-203, title IV, §4024(c), Dec. 22, 1987, 101 Stat. 1330-74, provided that: “The amendments made by subsections (a) and (b) [amending this section and section 1395n of this title] shall apply to items and services provided on or after January 1, 1988.”

Pub. L. 100-203, title IV, §4062(e), Dec. 22, 1987, 101 Stat. 1330-109, as amended by Pub. L. 101-508, title IV, §4152(h), Nov. 5, 1990, 104 Stat. 1388-80, provided that: “The amendments made by this section [enacting section 1395m of this title, amending this section and sections 1395k, 1395l, and 1395cc of this title, and repealing section 1395zz of this title] shall apply to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989 and to oxygen and oxygen equipment furnished on or after June 1, 1989.”

[Pub. L. 101-508, title IV, §4152(h), Nov. 5, 1990, 104 Stat. 1388-80, provided that amendment by that section to section 4062(e) of Pub. L. 100-203, set out above, is effective as if included in enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203.]

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98-617, §1(b), Nov. 8, 1984, 98 Stat. 3294, provided that: “The amendments made by this Act [probably means section 1 of Pub. L. 98-617, amending this section] shall apply to routine home care and other services included in hospice care furnished on or after October 1, 1984.”

Pub. L. 98-617, §3(c), Nov. 8, 1984, 98 Stat. 3296, provided that: “The amendments made by this section [amending this section and sections 1395l, 1395n, 1395r, 1395u, 1395x, 1395rr, 1395ww, 1396a, and 1396b of this title and amending provisions set out as notes under sections 1395h and 1395mm of this title] shall be effective as if they had been originally included in the Deficit Reduction Act of 1984 [Pub. L. 98-369].”

Pub. L. 98-369, div. B, title III, §2321(g), July 18, 1984, 98 Stat. 1085, provided that: “The amendments made by this section [enacting section 1395zz of this title and amending this section and sections 1395l, 1395x, and 1395cc of this title] shall apply to items and services furnished on or after the date of the enactment of this Act [July 18, 1984].”

Pub. L. 98-369, div. B, title III, §2335(g), July 18, 1984, 98 Stat. 1091, provided that: “The amendments made by this section [amending this section and sections 1395x, 1395z, 1395cc, 1396a, and 1396d of this title] shall become effective on the date of the enactment of this Act [July 18, 1984].”

Pub. L. 98-369, div. B, title III, §2336(c)(1), July 18, 1984, 98 Stat. 1091, provided that: “The amendments made by subsection (a) [amending this section and section 1395n of this title] shall apply to certifications and plans of care made or established on or after the date of the enactment of this Act [July 18, 1984].”

Amendment by section 2354(b)(1) of Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98-369, set out as a note under section 1320a-1 of this title.

Amendment by section 2354(c)(1)(A) of Pub. L. 98-369 effective as if originally included in Pub. L. 96-499, see section 2354(e)(2) of Pub. L. 98-369, set out as a note under section 1320a-1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98-21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98-21, set out as a note under section 1395ww of this title.

Amendment by Pub. L. 97-448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, see section 309(c)(2) of Pub. L. 97-448, set out as a note under section 426-1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(c)(1), (2) of Pub. L. 97-248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97-248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2121(b) of Pub. L. 97-35 applicable to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after Aug. 13, 1981, see section 2121(i) of Pub. L. 97-35, set out as a note under section 1395d of this title.

Pub. L. 97-35, title XXI, §2122(b), Aug. 13, 1981, 95 Stat. 797, provided that: "The amendments made by this section [amending this section and section 1395n of this title] shall apply to services furnished pursuant to plans of treatment implemented after the third month beginning after the date of the enactment of this Act [Aug. 13, 1981]."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 930(e), (f) of Pub. L. 96-499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96-499, set out as a note under section 1395x of this title.

Amendment by section 931(b) of Pub. L. 96-499 effective Apr. 1, 1981, see section 931(e) of Pub. L. 96-499, set out as a note under section 1395d of this title.

Pub. L. 96-499, title IX, §936(d), Dec. 5, 1980, 94 Stat. 2640, provided that: "The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply with respect to services provided on or after July 1, 1981."

Pub. L. 96-499, title IX, §941(c), Dec. 5, 1980, 94 Stat. 2641, provided that: "The amendments made by this section [amending this section] shall take effect on January 1, 1981."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95-292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95-292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95-142, §23(c), Oct. 25, 1977, 91 Stat. 1209, provided that: "The amendments made by this section [amending this section] shall apply to inpatient hospital services furnished on and after July 1, 1974."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93-233, §18(z-3)(2), Dec. 31, 1973, 87 Stat. 974, provided that: "The amendments made by subsection (k) [amending this section and section 1395y of this title] shall be effective with respect to admissions subject to the provisions of section 1814(a)(2) of the Social Security Act [42 U.S.C. 1395f(a)(2)] which occur after December 31, 1972."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92-603, title II, §211(d), Oct. 30, 1972, 86 Stat. 1384, provided that: "The amendments made by this

section [amending this section and sections 1395l, 1395u, 1395x, and 1395y of this title] shall apply to services furnished with respect to admissions occurring after December 31, 1972."

Amendment by section 226(c)(1) of Pub. L. 92-603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92-603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 227(b) of Pub. L. 92-603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92-603, set out as a note under section 1395x of this title.

Pub. L. 92-603, title II, §228(b), Oct. 30, 1972, 86 Stat. 1408, provided that: "The amendment made by subsection (a) [amending this section] and any regulations adopted pursuant to such amendment shall apply with respect to plans of care initiated on or after January 1, 1973, and with respect to admission to skilled nursing facilities and home health plans initiated on or after such date."

Pub. L. 92-603, title II, §233(f), Oct. 30, 1972, 86 Stat. 1412, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395l of this title] shall apply to services furnished by hospitals, extended care facilities, and home health agencies in accounting periods beginning after December 31, 1972. The amendments made by subsections (c), (d), and (e) [amending sections 706, 709, and 1396b of this title] shall apply with respect to services furnished by hospitals in accounting periods beginning after December 31, 1972." See, also, section 16 of Pub. L. 93-233, set out below.

Amendment by section 234(g)(1) of Pub. L. 92-603 applicable with respect to providers of services for fiscal years beginning after fifth month following October 1972, see section 234(i) of Pub. L. 92-603, set out as a note under section 1395x of this title.

Pub. L. 92-603, title II, §238(b), Oct. 30, 1972, 86 Stat. 1416, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to services furnished after the second month following the month in which this Act is enacted [October 1972]."

Pub. L. 92-603, title II, §247(c), Oct. 30, 1972, 86 Stat. 1425, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall be effective with respect to services furnished after December 31, 1972."

Pub. L. 92-603, title II, §256(d), Oct. 30, 1972, 86 Stat. 1447, provided that: "The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply with respect to admissions occurring after the second month following the month in which this Act is enacted [October 1972]."

Amendment by section 281(e) of Pub. L. 92-603 applicable in the case of services furnished (or deemed to have been furnished) after 1970, see section 281(g) of Pub. L. 92-603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90-248, title I, §126(c), Jan. 2, 1968, 81 Stat. 846, provided that: "The amendments made by this section [amending this section and section 1395n of this title] shall apply with respect to services furnished after the date of the enactment of this Act [Jan. 2, 1968]."

Amendment by section 129(c)(5), (6)(A) of Pub. L. 90-248 applicable with respect to services furnished after Jan. 2, 1968, see section 129(d) of Pub. L. 90-248, set out as a note under section 1395d of this title.

Amendment by section 143(c) of Pub. L. 90-248 applicable with respect to services furnished with respect to admissions occurring after Dec. 31, 1967, and to outpatient hospital diagnostic services furnished after Dec. 31, 1967, and before Apr. 1, 1968, see section 143(d) of Pub. L. 90-248, set out as a note under section 1395d of this title.

REVISION OF REGULATIONS REGARDING ACCESS TO
HOME HEALTH SERVICES

Pub. L. 98-369, div. B, title III, §2336(c)(2), July 18, 1984, 98 Stat. 1091, provided that: “The Secretary shall provide, not later than 90 days after the date of the enactment of this Act [July 18, 1984], for such revision of regulations as may be required to reflect the amendments made by subsection (b) [amending this section and section 1395n of this title].”

PROMULGATION OF REGULATIONS

Section 122(h)(2) of Pub. L. 97-248 provided that: “In order to provide for the timely implementation of the amendments made by this Act [probably means section 122 of Pub. L. 97-248, which amended this section and sections 1395c to 1395e, 1395h, and 1395x to 1395cc of this title and section 231f of Title 45, Railroads, and enacted provisions set out as notes under this section and sections 1395b-1 and 1395c of this title], the Secretary of Health and Human Services shall, not later than September 1, 1983, promulgate such final regulations as may be necessary to set forth—

“(A) a description of the care included in ‘hospice care’ and the standards for qualification of a ‘hospice program’, under section 1861(dd) of the Social Security Act [42 U.S.C. 1395x(dd)], and

“(B) the standards for payment for hospice care under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.], pursuant to section 1814(i) of such Act [42 U.S.C. 1395f(i)].”

APPLICATION OF 2010 AMENDMENT

Pub. L. 111-148, title VI, §6405(c), Mar. 23, 2010, 124 Stat. 768, provided that: “The Secretary [probably means the Secretary of Health and Human Services] may extend the requirement applied by the amendments made by subsections (a) [amending section 1395m of this title] and (b) [amending this section and section 1395n of this title] to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D-2(e) of such Act (42 U.S.C. 1395w-102(e)), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w-4(k)(3)(B)).”

Pub. L. 111-148, title VI, §6407(c), Mar. 23, 2010, 124 Stat. 770, provided that: “The Secretary [probably means the Secretary of Health and Human Services] may apply the face-to-face encounter requirement described in the amendments made by subsections (a) [amending this section and section 1395n of this title] and (b) [amending section 1395m of this title] to other items and services for which payment is provided under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.”

Pub. L. 111-148, title VI, §6407(d), Mar. 23, 2010, 124 Stat. 770, provided that: “The requirements pursuant to the amendments made by subsections (a) [amending this section and section 1395n of this title] and (b) [amending section 1395m of this title] shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act [42 U.S.C. 1395 et seq.].”

STUDY AND REPORT ON EFFECT OF 2000 AMENDMENT

Pub. L. 106-554, §1(a)(6) [title V, §507(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-532, provided that:

“(1) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the effect of the amendment [amending this section and section

1395n of this title] on the cost of and access to home health services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

“(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).”

STUDY AND REPORT ON PHYSICIAN CERTIFICATION
REQUIREMENT FOR HOSPICE BENEFITS

Pub. L. 106-554, §1(a)(6) [title III, §322(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-501, provided that:

“(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine the appropriateness of the certification regarding terminal illness of an individual under section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) that is required in order for such individual to receive hospice benefits under the medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.]. In conducting such study, the Secretary shall take into account the effect of the amendment made by subsection (a) [amending this section].

“(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary deems appropriate.”

TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE

Pub. L. 106-554, §1(a)(6) [title III, §321(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-501, provided that: “The provisions of this section [amending this section and enacting provisions set out as a note under this section] shall have no effect on the application of section 131 of BBRA [Pub. L. 106-113, §1000(a)(6) [title I, §131], set out as a note below].”

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §131], Nov. 29, 1999, 113 Stat. 1536, 1501A-333, provided that:

“(a) INCREASE FOR FISCAL YEARS 2001 AND 2002.—For purposes of payments under section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for hospice care furnished during fiscal years 2001 and 2002, the Secretary of Health and Human Services shall increase the payment rate in effect (but for this section) for—

“(1) fiscal year 2001, by 0.5 percent, and

“(2) fiscal year 2002, by 0.75 percent.

“(b) ADDITIONAL PAYMENT NOT BUILT INTO THE BASE.—The Secretary of Health and Human Services shall not include any additional payment made under this subsection (a) in updating the payment rate, as increased by the applicable market basket percentage increase for the fiscal year involved under section 1814(i)(1)(C)(ii) of that Act (42 U.S.C. 1395f(i)(1)(C)(ii)).”

STUDY AND REPORT TO CONGRESS REGARDING
MODIFICATION OF PAYMENT RATES FOR HOSPICE CARE

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §132], Nov. 29, 1999, 113 Stat. 1536, 1501A-333, provided that:

“(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and advisability of updating the payment rates and the cap amount determined with respect to a fiscal year under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) for routine home care and other services included in hospice care. Such study shall examine the cost factors used to determine such rates and such amount and shall evaluate whether such factors should be modified, eliminated, or supplemented with additional cost factors.

“(b) REPORT.—Not later than one year after the date of enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.”

STUDY OF METHODS TO COMPENSATE HOSPICES FOR
HIGH-COST CARE

Pub. L. 101-239, title VI, §6016, Dec. 19, 1989, 103 Stat. 2164, directed Secretary of Health and Human Services to conduct a study of high-cost hospice care provided to medicare beneficiaries under the medicare program, evaluate the ability of hospice programs participating in the medicare program to provide such high-cost care to such patients, develop methods to compensate such programs for providing such high-cost care, and submit, not later than Apr. 1, 1991, a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study, including in the report any recommendations developed by the Secretary to compensate hospice programs for providing high-cost hospice care to medicare beneficiaries.

CONTINUATION OF BAD DEBT RECOGNITION FOR
HOSPITAL SERVICES

Pub. L. 100-203, title IV, §4008(c), Dec. 22, 1987, 101 Stat. 1330-55, as amended by Pub. L. 100-647, title VIII, §8402, Nov. 10, 1987, 102 Stat. 3798; Pub. L. 101-239, title VI, §6023(a), Dec. 19, 1989, 103 Stat. 2167; Pub. L. 112-96, title III, §3201(d), Feb. 22, 2012, 126 Stat. 192, provided that: "In making payments to hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy. Effective for cost reporting periods beginning on or after October 1, 2012, the provisions of the previous two sentences shall not apply."

[Pub. L. 101-239, title VI, §6023(b), Dec. 19, 1989, 103 Stat. 2167, provided that: "The amendment made by subsection (a) [amending section 4008(c) of Pub. L. 100-203, set out above] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203]."]

[Pub. L. 100-647, title VIII, §8402, Nov. 10, 1987, 102 Stat. 3798, provided that amendment of section 4008(c) of Pub. L. 100-203, set out above, by section 8402 of Pub. L. 100-647 is effective as of date of enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, which was approved Dec. 22, 1987.]

PROVIDERS OF SERVICES TO CALCULATE AND REPORT
LESSER-OF-COST-OR-CHARGES DETERMINATIONS SEPARATELY
WITH RESPECT TO PAYMENTS UNDER PARTS
A AND B OF THIS SUBCHAPTER; ISSUANCE OF REGULATIONS

Pub. L. 98-369, div. B, title III, §2308(a), July 18, 1984, 98 Stat. 1074, provided that: "The Secretary of Health and Human Services shall issue regulations which require, for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], that providers of services calculate and report the lesser-of-cost-or-charges determinations separately with respect to payments for services under part A and services under part B of such title (other than clinical diagnostic laboratory tests paid under section 1833(h) [42 U.S.C. 1395(h)]), and that payment under such title be based upon such separate

determinations. Such regulations shall apply to cost reporting periods beginning on or after October 1, 1984."

DETERMINATION OF NOMINAL CHARGES FOR APPLYING
NOMINALITY TEST

Pub. L. 98-369, div. B, title III, §2308(b)(1), July 18, 1984, 98 Stat. 1074, provided that: "For purposes of applying the nominality test under sections 1814(b)(2) [42 U.S.C. 1395f(b)(2)] and 1833(a)(2)(B)(ii) [42 U.S.C. 1395l(a)(2)(B)(ii)] of the Social Security Act, the Secretary shall, in addition to those rules for establishing nominality which the Secretary determines to be appropriate, provide that charges representing 60 percent or less of costs shall be considered nominal. The charges used in making such determinations shall be the charges actually billed to charge-paying patients who are not entitled to benefits under either part of such title [42 U.S.C. 1395c et seq., 1395j et seq.]. Such determination shall be made separately with respect to payments for services under part A and services under part B of such title (other than clinical diagnostic laboratory tests paid under section 1833(h)), or on the basis of inpatient and outpatient services, except that the determination need not be made separately for home health services if the Secretary finds that such separation is not appropriate."

STUDY AND REPORT RELATING TO THE REIMBURSEMENT
METHOD AND BENEFIT STRUCTURE FOR HOSPICE CARE;
SUPERVISION OF REPORT BY COMPTROLLER GENERAL

Pub. L. 97-248, title I, §122(j), formerly §122(i), Sept. 3, 1982, 96 Stat. 363, as redesignated by Pub. L. 97-448, title III, §309(a)(6), Jan. 12, 1983, 96 Stat. 2408, provided that:

"(1) The Secretary of Health and Human Services shall conduct a study and, prior to January 1, 1986, report to the Congress on whether or not the reimbursement method and benefit structure (including copayments) for hospice care under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] are fair and equitable and promote the most efficient provision of hospice care. Such report shall include the feasibility and advisability of providing for prospective reimbursement for hospice care, an evaluation of the inclusion of payment for outpatient drugs, an evaluation of the need to alter the method of reimbursement for nutritional, dietary, and bereavement counseling as hospice care, and any recommendations for legislative changes in the hospice care reimbursement or benefit structure.

"(2) The Comptroller General shall monitor and evaluate the study and the preparation of the report under paragraph (1)."

WAIVER OF LIMITATIONS TO ALLOW PRE-EXISTING
HOSPICES TO PARTICIPATE AS A HOSPICE PROGRAM

Pub. L. 97-248, title I, §122(k), formerly §122(j), Sept. 3, 1982, 96 Stat. 363, as redesignated and amended by Pub. L. 97-448, title III, §309(a)(6), (7), Jan. 12, 1983, 96 Stat. 2408, provided that: "The Secretary of Health and Human Services shall grant waivers of the limitations imposed by section 1814(i)(2) of the Social Security Act [42 U.S.C. 1395f(i)(2)] (relating to the cap amount), section 1861(dd)(1)(G) of such Act [42 U.S.C. 1395x(dd)(1)(G)] (relating to the limitations on the frequency and number of respite care days), and section 1861(dd)(2)(A)(iii) of such Act [42 U.S.C. 1395x(dd)(2)(A)(iii)] (relating to the aggregate limit on the number of days of inpatient care), as may be necessary to allow any institution which commenced operations as a hospice prior to January 1, 1975, to participate until October 1, 1986, in a viable manner as a hospice program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]"

MEDICARE PAYMENT BASIS FOR SERVICES PROVIDED BY
AGENCIES AND PROVIDERS; EFFECTIVE DATE

Pub. L. 93-233, §16, Dec. 31, 1973, 87 Stat. 967, provided that: "In the administration of titles V, XVIII, and XIX of the Social Security Act [42 U.S.C. 701 et seq., 1395 et seq., 1396 et seq.], the amount payable under such title

to any provider of services on account of services provided by such hospital, skilled nursing facility, or home health agency shall be determined (for any period with respect to which the amendments made by section 233 of Public Law 92-603 [this section and sections 706, 709, 1395f, and 1396b of this title] would, except for the provisions of this section, be applicable) in like manner as if the date contained in the first and second sentences of subsection (f) of such section 233 [set out as an Effective Date of 1972 Amendment note above] were December 31, 1973, rather than December 31, 1972."

§ 1395g. Payments to providers of services

(a) Determination of amount

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the Government Accountability Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

(b) Conditions

No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1395x(w)(2) of this title, to have in effect an arrangement with a quality improvement organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this subchapter for utilization review activities provided by a quality improvement organization pursuant to an arrangement or deemed arrangement with a hospital under section 1395x(w)(2) of this title shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.

(c) Payments under assignment or power of attorney

No payment which may be made to a provider of services under this subchapter for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of com-

petent jurisdiction, or (2) to preclude an agent of the provider of services 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 provider under this subchapter 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.

(d) Accrual of interest on balance of excess or deficit not paid

Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(e) Periodic interim payments

(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title, and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d) Puerto Rico hospital (as defined in section 1395ww(d)(9)(A) of this title) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1395h of this title, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

(B) In the case of a hospital that—

(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section) of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

(ii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(C) In the case of a hospital that—

(i) is located in a rural area,

(ii) has 100 or fewer beds, and

(iii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic in-

terim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986, in the cases described in subparagraphs (A) through (D)) with respect to—

(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title);

(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1395f(b)(3) or 1395ww(c) of this title, if payment on a periodic interim payment basis is an integral part of such reimbursement system;

(C) extended care services;

(D) hospice care; and

(E) inpatient critical access hospital services;

if the provider of such services elects to receive, and qualifies for, such payments.

(3) In the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1395ww of this title) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.

(4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if—

(A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and

(B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such hospitals or campuses were treated as independent hospitals for purposes of this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, § 1815, as added Pub. L. 89-97, title I, § 102(a), July 30, 1965, 79 Stat. 297; amended Pub. L. 94-182, title I, § 112(a)(2), Dec. 31, 1975, 89 Stat. 1055; Pub. L. 95-142, § 2(a)(2), Oct. 25, 1977, 91 Stat. 1175; Pub. L. 96-473, § 6(i), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 97-248, title I, §§ 117(a)(1), 148(b), Sept. 3, 1982, 96 Stat. 354, 394; Pub. L. 99-509, title IX, § 9311(a)(1), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 101-239, title VI, § 6021(a), Dec. 19, 1989, 103 Stat. 2166; Pub. L. 105-33, title IV, § 4603(b), Aug. 5, 1997, 111 Stat. 470; Pub. L. 108-173, title IV, § 405(c)(1), title VII, § 736(a)(3), Dec. 8, 2003, 117 Stat. 2266, 2354; Pub. L. 108-271, § 8(b), July 7, 2004, 118 Stat. 814; Pub. L. 112-40, title II, § 261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423.)

AMENDMENTS

2011—Subsec. (b). Pub. L. 112-40 substituted “quality improvement” for “quality control and peer review” in two places.

2004—Subsec. (a). Pub. L. 108-271 substituted “Government Accountability Office” for “General Accounting Office”.

2003—Subsec. (e)(1)(B). Pub. L. 108-173, § 736(a)(3), substituted “of a hospital” for “of hospital” in introductory provisions.

Subsec. (e)(2). Pub. L. 108-173, § 405(c)(1)(A), inserted “, in the cases described in subparagraphs (A) through (D)” after “1986” in introductory provisions.

Subsec. (e)(2)(E). Pub. L. 108-173, § 405(c)(1)(B)–(D), added subpar. (E).

1997—Subsec. (e)(2)(C) to (E). Pub. L. 105-33 inserted “and” at end of subpar. (C), redesignated subpar. (E) as (D), and struck out former subpar. (D) which read as follows: “home health services; and”.

1989—Subsec. (e)(4). Pub. L. 101-239 added par. (4).

1986—Subsec. (e). Pub. L. 99-509 added subsec. (e).

1982—Subsec. (b). Pub. L. 97-248, § 148(b), substituted “quality control and peer review organization” for “Professional Standards Review Organization” wherever appearing.

Subsec. (d). Pub. L. 97-248, § 117(a)(1), added subsec. (d).

1980—Subsec. (c). Pub. L. 96-473 substituted “for or in connection with” for “for on in connection with”.

1977—Subsec. (c). Pub. L. 95-142 added subsec. (c).

1975—Pub. L. 94-182 designated existing provisions as subsec. (a) and added subsec. (b).

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112-40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112-40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title IV, § 405(c)(3), Dec. 8, 2003, 117 Stat. 2267, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to payments made on or after July 1, 2004.”

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105-33, set out as an Effective Date note under section 1395fff of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-239, title VI, § 6021(b), Dec. 19, 1989, 103 Stat. 2167, provided that: “The amendment made by subsection (a) [amending this section] shall apply to payments made for discharges occurring on or after the expiration of the 30-day period that begins on the date of the enactment of this Act [Dec. 19, 1989], regardless of the date of the merger or consolidation involved.”

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99-509, title IX, § 9311(a)(2), Oct. 21, 1986, 100 Stat. 1997, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to claims received on or after July 1, 1987.”

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97-248, title I, § 117(b), Sept. 3, 1982, 96 Stat. 355, provided that: “The amendments made by subsection (a) [amending this section and section 1395f of this title] apply to final determinations made on or after the date of the enactment of this Act [Sept. 3, 1982].”

Amendment by section 148(b) of Pub. L. 97-248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97-248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95-142, § 2(a)(4), Oct. 25, 1977, 91 Stat. 1176, provided that: “The amendments made by this subsection [amending this section and sections 1395u and 1396a of this title] shall apply with respect to care and services

furnished on or after the date of the enactment of this Act [Oct. 25, 1977].”

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 94-182 effective with respect to utilization review activities conducted on and after the first day of the first month which begins more than 30 days after Dec. 31, 1975, see section 112(d) of Pub. L. 94-182, set out as a note under section 1395x of this title.

DEVELOPMENT OF ALTERNATIVE TIMING METHODS OF PERIODIC INTERIM PAYMENTS

Pub. L. 108-173, title IV, §405(c)(2), Dec. 8, 2003, 117 Stat. 2267, provided that: “With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act [42 U.S.C. 1395g(e)(2)(E)], as added by paragraph (1), the Secretary [of Health and Human Services] shall develop alternative methods for the timing of such payments.”

TRANSITION

Pub. L. 99-509, title IX, §9311(a)(3), Oct. 21, 1986, 100 Stat. 1997, provided that: “Upon the request of a hospital which—

“(A) as of June 30, 1987, is receiving payments under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] for inpatient hospital services on a periodic interim payment basis,

“(B) requests continuation of payment on such basis, and

“(C) is paid through an agency or organization with an agreement under section 1816 of such Act [42 U.S.C. 1395h],

the Secretary of Health and Human Services shall continue payment on such a basis until not earlier than the end of the first period of three consecutive calendar months (beginning no earlier than April 1987) during all of which the agency or organization has met the requirements of section 1816(c)(2) of such Act (relating to prompt payment of claims).”

DELAY IN PERIODIC INTERIM PAYMENTS

Pub. L. 97-248, title I, §120, Sept. 3, 1982, 96 Stat. 355, provided that: “Notwithstanding section 1815(a) of the Social Security Act [42 U.S.C. 1395g(a)], in the case of a hospital which is paid periodic interim payments under such section, the Secretary of Health and Human Services shall provide that—

“(1) with respect to the last 21 days for which such payments would otherwise be made during fiscal year 1983, such payments shall be deferred until fiscal year 1984; and

“(2) with respect to the last 21 days for which such payments would otherwise be made during fiscal year 1984, such payments shall be deferred until fiscal year 1985.”

Pub. L. 96-499, title IX, §959, Dec. 5, 1980, 94 Stat. 2650, provided for deferral of interim payments to be made during last twenty-one days of fiscal year 1981 until fiscal year 1982, prior to repeal by Pub. L. 97-35, title XXI, §2155, Aug. 13, 1981, 95 Stat. 802.

§ 1395h. Provisions relating to the administration of part A

(a) In general

The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1395kk-1 of this title.

(b) Repealed. Pub. L. 108-173, title IX, §911(b)(3), Dec. 8, 2003, 117 Stat. 2383

(c) Prompt payment of claims

(1) Repealed. Pub. L. 108-173, title IX, §911(b)(4)(A), Dec. 8, 2003, 117 Stat. 2383.

(2)(A) Each contract under section 1395kk-1 of this title that provides for making payments under this part shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this subchapter—

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term “clean claim” means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subchapter.

(ii) The term “applicable number of calendar days” means—

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days,

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days, and

(V) with respect to claims received in the 12-month period beginning October 1, 1993, and claims received in any succeeding 12-month period, 30 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, critical access hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31 (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each contract under section 1395kk-1 of this title that provides for making payments under this part shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this subchapter within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term “applicable number of calendar days” means—

(i) with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and

(ii) with respect to claims submitted otherwise, 28 days.

(d) to (i). Repealed. Pub. L. 108-173, title IX, § 911(b)(5), Dec. 8, 2003, 117 Stat. 2383**(j) Denial of claim; notification and reconsideration**

A contract with a medicare administrative contractor under section 1395kk-1 of this title with respect to the administration of this part shall require that, with respect to a claim for home health services, extended care services, or post-hospital extended care services submitted by a provider to such medicare administrative contractor that is denied, such medicare administrative contractor—

(1) furnish the provider and the individual with respect to whom the claim is made with a written explanation of the denial and of the statutory or regulatory basis for the denial; and

(2) in the case of a request for reconsideration of a denial, promptly notify such individual and the provider of the disposition of such reconsideration.

(k) Annual reporting requirement on erroneous payment recovery

A contract with a medicare administrative contractor under section 1395kk-1 of this title with respect to the administration of this part shall require that such medicare administrative contractor submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1395y(b)(2)(A) of this title).

(l) Repealed. Pub. L. 108-173, title IX, § 911(b)(7), Dec. 8, 2003, 117 Stat. 2383

(Aug. 14, 1935, ch. 531, title XVIII, § 1816, as added Pub. L. 89-97, title I, § 102(a), July 30, 1965, 79 Stat. 297; amended Pub. L. 92-603, title II, § 243(b), Oct. 30, 1972, 86 Stat. 1422; Pub. L. 95-142, § 14(a), Oct. 25, 1977, 91 Stat. 1198; Pub. L. 96-499, title IX, § 930(o), Dec. 5, 1980, 94 Stat. 2632; Pub. L. 97-248, title I, § 122(c)(3), Sept. 3, 1982, 96 Stat. 359; Pub. L. 98-369, div. B, title III, § 2326(b), (c)(1), (d)(1), July 18, 1984, 98 Stat. 1087; Pub. L. 99-509, title IX, §§ 931(b), 9352(a)(2), Oct. 21, 1986, 100 Stat. 1997, 2044; Pub. L. 100-203, title IV, §§ 4031(a)(1), 4032(a), (b), 4035(a)(1), 4085(d)(1), Dec. 22, 1987, 101 Stat. 1330-75 to 1330-78, 1330-130; Pub. L. 100-360, title II, § 203(f), title IV, § 411(e)(1)(B), July 1, 1988, 102 Stat. 725, 775; Pub. L. 101-234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101-239, title VI, §§ 6003(g)(3)(D)(vi), 6202(d)(1), Dec. 19, 1989, 103 Stat. 2153, 2234; Pub. L. 101-508, title IV, § 4005(c)(1)(A), Nov. 5, 1990, 104 Stat. 1388-41; Pub. L. 103-66, title XIII, § 13568(a), (b), Aug. 10, 1993, 107 Stat. 608; Pub. L. 103-432, title I, §§ 110(d)(2), 151(b)(1)(A), (2)(A), Oct. 31, 1994, 108 Stat. 4408, 4433, 4434; Pub. L. 104-191, title II, § 202(b)(1), Aug. 21, 1996, 110 Stat. 1998; Pub. L. 105-33, title IV, § 4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108-173, title VII, § 736(a)(4), title IX, § 911(b), Dec. 8, 2003, 117 Stat. 2355, 2383; Pub. L. 109-171, title V, § 5202(a)(1), Feb. 8, 2006, 120 Stat. 47.)

AMENDMENTS

2006—Subsec. (c)(3)(B)(ii). Pub. L. 109-171 substituted “28 days” for “26 days”.

2003—Pub. L. 108-173, § 911(b)(1), substituted “Provisions relating to the administration of part A” for “Use of public or private agencies or organizations to facilitate payment to providers of services” in section catchline.

Subsec. (a). Pub. L. 108-173, § 911(b)(2), amended subsec. (a) generally. Prior to amendment, subsec. (a) authorized Secretary to enter into agreements with agencies or organizations to determine and pay amounts under this part.

Subsec. (b). Pub. L. 108-173, § 911(b)(3), struck out subsec. (b), which set forth prerequisites for agreement or renewal of agreement.

Subsec. (c)(1). Pub. L. 108-173, § 911(b)(4)(A), struck out par. (1), which related to terms and conditions of agreements.

Subsec. (c)(2)(A). Pub. L. 108-173, § 911(b)(4)(B), substituted “contract under section 1395kk-1 of this title that provides for making payments under this part” for “agreement under this section” in introductory provisions.

Subsec. (c)(2)(B)(ii)(III). Pub. L. 108-173, § 736(a)(4)(A), struck out “and” at end.

Subsec. (c)(2)(B)(ii)(IV). Pub. L. 108-173, § 736(a)(4)(B), substituted “, and” for period at end.

Subsec. (c)(3)(A). Pub. L. 108-173, § 911(b)(4)(B), substituted “contract under section 1395kk-1 of this title that provides for making payments under this part” for “agreement under this section”.

Subsecs. (d) to (i). Pub. L. 108-173, § 911(b)(5), struck out subsecs. (d) to (i), which related to nomination of agency or organization, designation of agency or organization to perform provider services, standards, criteria, and procedures for evaluation of agency or organization performance, termination of agreement, bonding requirement for officers and employees, and liability of certifying and disbursing officers.

Subsec. (j). Pub. L. 108-173, § 911(b)(6), in introductory provisions, substituted “A contract with a medicare administrative contractor under section 1395kk-1 of this title with respect to the administration of this part” for “An agreement with an agency or organization under this section” and “such medicare administrative contractor” for “such agency or organization” in two places.

Subsec. (k). Pub. L. 108-173, § 911(b)(6), substituted “A contract with a medicare administrative contractor under section 1395kk-1 of this title with respect to the administration of this part” for “An agreement with an agency or organization under this section” and “such medicare administrative contractor” for “such agency or organization”.

Subsec. (l). Pub. L. 108-173, § 911(b)(7), struck out subsec. (l), which prohibited any activity pursuant to an agreement under this section that is carried out pursuant to a contract under the Medicare Integrity Program.

1997—Subsec. (c)(2)(C). Pub. L. 105-33 substituted “critical access” for “rural primary care”.

1996—Subsec. (l). Pub. L. 104-191 added subsec. (l).

1994—Subsec. (f)(1)(A). Pub. L. 103-432, § 151(b)(2)(A), inserted “(including the agency’s or organization’s success in recovering payments made under this subchapter for services for which payment has been or could be made under a primary plan (as defined in section 1395y(b)(2)(A) of this title))” after “processing”.

Subsec. (f)(2)(A)(ii). Pub. L. 103-432, § 110(d)(2), substituted “such agency’s” for “such agency”.

Subsec. (k). Pub. L. 103-432, § 151(b)(1)(A), added subsec. (k).

1993—Subsec. (c)(2)(B)(ii)(IV), (V). Pub. L. 103-66, § 13568(b), substituted “period ending on or before September 30, 1993” for “period” in subcl. (IV) and added subcl. (V).

Subsec. (c)(3)(B). Pub. L. 103-66, § 13568(a), added cls. (i) and (ii) and struck out former cls. (i) and (ii) which read as follows:

“(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

“(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days.”

1990—Subsec. (f). Pub. L. 101-508 designated existing provisions as par. (1), redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, struck out “Such standards and criteria” and all that follows, which was executed by striking out “Such standards and criteria shall be published in the Federal Register, and opportunity shall be provided for public comment prior to implementation. Such standards and criteria shall include with respect to claims for services furnished under this part by any provider of services other than a hospital whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of the fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days and the extent to which its determinations are reversed on appeal.”, and added par. (2).

1989—Subsec. (c)(1). Pub. L. 101-239, § 6202(d)(1), inserted at end “The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1395hh of this title, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1395y(b) of this title may apply.”

Subsec. (c)(2)(C). Pub. L. 101-239, § 6003(g)(3)(D)(vi), inserted “rural primary care hospital,” after “hospital.”

Subsec. (k). Pub. L. 101-234 repealed Pub. L. 100-360, § 203(f), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (j)(2). Pub. L. 100-360, § 411(e)(1)(B), inserted “in the case of a request for reconsideration of a denial,” and substituted “the disposition” for “disposition”.

Subsec. (k). Pub. L. 100-360, § 203(f), added subsec. (k) relating to use of regional intermediaries in administration of benefits.

1987—Subsec. (c)(1). Pub. L. 100-203, § 4035(a)(1), inserted at end “The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.”

Subsec. (c)(2)(C). Pub. L. 100-203, § 4085(d)(1), substituted “hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency” for “or hospice program”.

Subsec. (c)(3). Pub. L. 100-203, § 4031(a)(1), added par. (3).

Subsec. (f). Pub. L. 100-203, § 4023(b), inserted at end “Such standards and criteria shall include with respect to claims for services furnished under this part by any provider of services other than a hospital whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of the fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days and the extent to which its determinations are reversed on appeal.”

Subsec. (j). Pub. L. 100-203, § 4032(a), added subsec. (j).

1986—Subsec. (a). Pub. L. 99-509, § 9352(a)(2), inserted at end “As used in this subchapter and part B of subchapter XI of this chapter, the term ‘fiscal intermediary’ means an agency or organization with a contract under this section.”

Subsec. (c). Pub. L. 99-509, § 9311(b), designated existing provisions as par. (1) and added par. (2).

1984—Subsec. (c). Pub. L. 98-369, § 2326(d)(1), inserted provision that the Secretary, in determining the necessary and proper cost of administration with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement.

Subsec. (e)(4). Pub. L. 98-369, § 2326(b), inserted provision that not later than July 1, 1987, the Secretary limit the number of regional agencies or organizations to not more than ten.

Subsec. (f). Pub. L. 98-369, § 2326(c)(1), struck out in cl. (2) “, by regulation,” after “Secretary shall establish” and inserted provision that the standards and criteria be published in the Federal Register and an opportunity be provided for public comment prior to implementation.

1982—Subsec. (e)(5). Pub. L. 97-248 added par. (5).

1980—Subsec. (e)(2). Pub. L. 96-499, § 930(o)(1), inserted “(subject to the provisions of paragraph (4))”.

Subsec. (e)(4). Pub. L. 96-499, § 930(o)(2), added par. (4).

1977—Subsec. (a). Pub. L. 95-142, § 14(a)(1), inserted provisions relating to applicability to providers assigned to the agency or organization under subsec. (e) of this section.

Subsec. (b). Pub. L. 95-142, § 14(a)(2), substituted provisions setting forth criteria for agreements by the Secretary or renewal of such agreements with agencies or organizations, for provisions setting forth criteria for agreements by the Secretary with agencies or organizations.

Subsecs. (e), (f). Pub. L. 95-142, § 14(a)(4), (5), added subsecs. (e) and (f). Former subsecs. (e) and (f) redesignated (g) and (h), respectively.

Subsec. (g). Pub. L. 95-142, § 14(a)(3), (4), redesignated former subsec. (e) as (g) and inserted provisions relating to applicability of standards, etc., developed under subsec. (f) of this section. Former subsec. (g) redesignated (i).

Subsecs. (h), (i). Pub. L. 95-142, § 14(a)(4), redesignated former subsecs. (f) and (g) as (h) and (i), respectively.

1972—Subsec. (a). Pub. L. 92-603 inserted reference to provisions of section 1395oo of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109-171, title V, § 5202(b), Feb. 8, 2006, 120 Stat. 47, provided that: “The amendments made by this section [amending this section and section 1395u of this title] shall apply to claims submitted on or after January 1, 2006.”

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 911(b) of Pub. L. 108-173 effective Oct. 1, 2005, except as otherwise provided, with transition rules authorizing Secretary of Health and Human Services to continue to enter into agreements under this section prior to such date, and provisions authorizing continuation of Medicare Integrity Program functions during the period that begins on Dec. 8, 2003, and ends on Oct. 1, 2011, see section 911(d) of Pub. L. 108-173, set out as an Effective Date; Transition Rule note under section 1395kk-1 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105-33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103-432, title I, § 151(b)(4), Oct. 31, 1994, 108 Stat. 4435, provided that: “The amendments made by paragraphs (1) and (2) [amending this section and section 1395u of this title] shall apply to contracts with fiscal intermediaries and carriers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for contract years beginning with 1995.”

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103-66, title XIII, § 13568(c), Aug. 10, 1993, 107 Stat. 608, provided that: “The amendments made by this section [amending this section and section 1395u of this title] shall apply to claims received on or after October 1, 1993.”

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-239, title VI, § 6202(d)(3), Dec. 19, 1989, 103 Stat. 2234, provided that: “The amendments made by

this subsection [amending this section and section 1395u of this title] shall apply to agreements and contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 19, 1989].”

Amendment by Pub. L. 101-234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101-234, set out as a note under section 1320a-7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(f) of Pub. L. 100-360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100-360, set out as a note under section 1320c-3 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(e)(1)(B) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100-203, title IV, §4031(a)(3)(A), Dec. 22, 1987, 101 Stat. 1330-76, provided that: “The amendments made by paragraphs (1) and (2) [amending this section and section 1395u of this title] shall apply to claims received on or after July 1, 1988.”

Pub. L. 100-203, title IV, §4032(c)(1), Dec. 22, 1987, 101 Stat. 1330-77, as amended by Pub. L. 100-360, title IV, §411(e)(1)(C), July 1, 1988, 102 Stat. 775, provided that:

“(A) The amendment made by subsection (a) [amending this section] shall apply with respect to claims received on or after January 1, 1988.

“(B) The amendment made by subsection (b) [amending this section] shall apply with respect to reconsiderations requested on or after October 1, 1988.”

Pub. L. 100-203, title IV, §4035(a)(3), Dec. 22, 1987, 101 Stat. 1330-78, provided that: “The amendments made by this section [amending this section and sections 1395u and 1395hh of this title] shall take effect on the date of the enactment of this Act [Dec. 22, 1987] and shall apply to budgets for fiscal years beginning with fiscal year 1989.”

Pub. L. 100-203, title IV, §4085(d)(2), Dec. 22, 1987, 101 Stat. 1330-131, provided that:

“(A) The amendment made by paragraph (1) [amending this section] shall apply to claims received on or after the date of enactment of this Act [Dec. 22, 1987].

“(B) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 [42 U.S.C. 1395h], and regulations, to such extent as may be necessary to implement the amendment made by paragraph (1).”

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99-509, title IX, §9311(d), Oct. 21, 1986, 100 Stat. 1999, provided that:

“(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) [amending this section and section 1395u of this title] shall apply to claims received on or after November 1, 1986.

“(2) Sections 1816(c)(2)(C) [sic] and 1842(c)(2)(C) of the Social Security Act [42 U.S.C. 1395h(c)(2)(C), 1395u(c)(2)(C)], as added by such amendments, shall apply to claims received on or after April 1, 1987.

“(3) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h] and contracts under section 1842 of such Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the provisions of this Act on a timely basis.”

Amendment by section 9352(a)(2) of Pub. L. 99-509 to be implemented by Secretary of Health and Human Services not later than 6 months after Oct. 21, 1986, see section 9352(c)(1) of Pub. L. 99-509, set out as a note under section 1320c-2 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98-369, div. B, title III, §2326(d)(3), July 18, 1984, 98 Stat. 1088, provided that: “The amendments

made by this subsection [amending this section and section 1395u of this title] shall apply to agreements and contracts entered into or renewed after September 30, 1984.”

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97-248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97-248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96-499 effective Dec. 5, 1980, see section 930(s)(1) of Pub. L. 96-499, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95-142, §14(c), (d), Oct. 25, 1977, 91 Stat. 1200, provided that:

“(c) The amendment made by paragraphs (2) and (3) of subsection (a) [amending this section] to the extent that they require application of standards, criteria, and procedures developed under section 1816(f) of the Social Security Act [42 U.S.C. 1395h(f)] shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

“(d) Except as provided in subsection (c), the amendment made by subsection (a)(2) [amending this section] shall apply to agreements entered into or renewed on or after the date of enactment of this Act [Oct. 25, 1977].”

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92-603 applicable with respect to cost reports of providers of services for accounting periods ending on or after June 30, 1973, see section 243(c) of Pub. L. 92-603, set out as an Effective Date note under section 1395oo of this title.

ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS

Pub. L. 100-360, title IV, §427, July 1, 1988, 102 Stat. 814, which provided that the Administrator of the Health Care Financing Administration was to establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials, was repealed by Pub. L. 101-234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985.

AMENDMENTS TO AGREEMENTS AND CONTRACTS NECESSARY TO IMPLEMENT SECTION 4031(a) OF PUB. L. 100-203

Pub. L. 100-203, title IV, §4031(a)(3)(B), Dec. 22, 1987, 101 Stat. 1330-76, provided that: “The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h] and contracts under section 1842 of such Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the provisions of this subsection [amending this section and section 1395u of this title] on a timely basis.”

PROHIBITION OF POLICIES OTHER THAN AS PROVIDED BY SECTION 4031 OF PUB. L. 100-203 INTENDED TO SLOW DOWN MEDICARE PAYMENTS; BUDGET CONSIDERATIONS

Pub. L. 100-203, title IV, §4031(b), (c), Dec. 22, 1987, 101 Stat. 1330-76, provided that, notwithstanding any other provision of law, the Secretary of Health and Human Services was not authorized to issue, after Dec. 22, 1987, and before Oct. 1, 1990, any final regulation, instruction, or other policy change which was primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under this subchapter, and that section 4031 of Pub. L. 100-203, amend-

ing this section and section 1395u of this title and enacting provisions set out as notes under this section, was a necessary (but secondary) result of a significant policy change.

AMENDMENTS TO AGREEMENTS AND CONTRACTS NECESSARY TO IMPLEMENT SECTION 4032(a), (b) OF PUB. L. 100-203

Pub. L. 100-203, title IV, §4032(c)(2), Dec. 22, 1987, 101 Stat. 1330-77, provided that: "The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 [42 U.S.C. 1395h] and contracts under section 1842 of the Social Security Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the amendments made by subsections (a) and (b) [amending this section] on a timely basis."

REPLACEMENT OF AGENCY, ORGANIZATION, OR CARRIER PROCESSING MEDICARE CLAIMS; NUMBER OF AGREEMENTS AND CONTRACTS AUTHORIZED FOR FISCAL YEARS 1985 THROUGH 1993

Pub. L. 98-369, div. B, title III, §2326(a), July 18, 1984, 98 Stat. 1087, as amended by Pub. L. 98-617, §3(a)(2), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99-509, title IX, §9321(b), Oct. 21, 1986, 100 Stat. 2016; Pub. L. 101-239, title VI, §6215(a), Dec. 19, 1989, 103 Stat. 2252; Pub. L. 103-432, title I, §159(a), Oct. 31, 1994, 108 Stat. 4443, provided that: "During each fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1993), the Secretary of Health and Human Services may enter into not more than two agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h], and not more than two contracts under section 1842 of such Act [42 U.S.C. 1395u], on the basis of competitive bidding, without regard to the nominating process under section 1816(a) of such Act or cost reimbursement provisions under sections 1816(c) or 1842(c) of such Act during the term of the agreement. Such procedure may be used only for the purpose of replacing an agency or organization or carrier which over a 2-year period of time has been in the lowest 20th percentile of agencies and organizations or carriers having agreements or contracts under the respective section, as measured by the Secretary's cost and performance criteria. In addition, beginning with fiscal year 1990 and any subsequent fiscal year the Secretary may enter into such additional agreements and contracts without regard to such cost reimbursement provisions if the fiscal intermediary or carrier involved and the Secretary agree to waive such provisions, but the Secretary may not take any action that has the effect of requiring that the intermediary or carrier agree to waive such provisions, including requiring such a waiver as a condition for entering into or renewing such an agreement or contract. Any agency or organization or carrier selected on the basis of competitive bidding must perform all of the duties listed in section 1816(a) of such Act, or the duties listed in paragraphs (1) through (4) of section 1842(a) of such Act, as the case may be, and must be a health insuring organization (as determined by the Secretary)."

[Pub. L. 103-432, title I, §159(b), Oct. 31, 1994, 108 Stat. 4443, provided that: "The amendment made by subsection (a) [amending section 2326(a) of Pub. L. 98-369, set out above] shall apply beginning with fiscal year 1994."]

[Pub. L. 101-239, title VI, §6215(b), Dec. 19, 1989, 103 Stat. 2252, provided that: "The amendments made by subsection (a) [amending section 2326(a) of Pub. L. 98-369, set out above] shall apply beginning with fiscal year 1990."]

AUDIT AND MEDICAL CLAIMS REVIEW

Pub. L. 97-248, title I, §118, Sept. 3, 1982, 96 Stat. 355, as amended by Pub. L. 99-272, title IX, §9216(a), Apr. 7, 1986, 100 Stat. 180, provided that, in addition to any funds otherwise provided for payments to intermediaries and carriers under agreements entered into under this section and section 1395u of this title, there

were transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Fund an additional \$45,000,000 for each of fiscal years 1983, 1984, and 1985, and \$105,000,000 for each of fiscal years 1986, 1987, and 1988 for payments to such intermediaries and carriers under such agreements to be used exclusively for purposes of carrying out provider cost audits, of reviewing medical necessity, and of recovering third-party liability payments.

DEVELOPMENTAL DATE FOR STANDARDS, CRITERIA, AND PROCEDURES PURSUANT TO SUBSEC. (f) OF THIS SECTION

Pub. L. 95-142, §14(b), Oct. 15, 1977, 91 Stat. 1200, directed the Secretary of Health, Education, and Welfare to develop the standards, criteria, and procedures described in subsection (f) of section 1816 of the Social Security Act [42 U.S.C. 1395h(f)] (as added by subsection (a)(5)) not later than Oct. 1, 1978.

§ 1395i. Federal Hospital Insurance Trust Fund

(a) Creation; deposits; transfers from Treasury

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1986 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Commissioner of Social Security on the basis of records of wages established and maintained by the Commissioner of Social Security in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1986 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Commissioner of Social Security on the basis of records of self-employment established and maintained by the Commissioner of Social Security in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent

prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) Board of Trustees; composition; meetings; duties

With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the “Board of Trustees”) composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member’s term until the earlier of the time at which the member’s successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member’s term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the “Managing Trustee”). The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.¹

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary of the Centers

for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) Investment of Trust Fund by Managing Trustee

It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Authority of Managing Trustee to sell obligations

Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) Interest on and proceeds from sale or redemption of obligations

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) Payment of estimated taxes

(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the

¹ So in original. See 2003 Amendment note below.

Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1986 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Commissioner of Social Security in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1986, and the Commissioner of Social Security shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) Transfers from other Funds

There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1395gg(b) of this title. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1395gg(b) of this title.

(h) Payments from Trust Fund amounts certified by Secretary

The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 401(g)(1) of this title.

(i) Payment of travel expenses for travel within United States; reconsideration interviews and proceedings before administrative law judges

There are authorized to be made available for expenditure out of the Trust Fund such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 410(i) of this title) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this subchapter. The amount available under the preced-

ing sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(j) Loans from other Funds; interest; repayment; report to Congress

(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Hospital Insurance Trust Fund, the Managing Trustee may, subject to paragraph (5), borrow such amounts as he determines to be appropriate from either the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund for transfer to and deposit in the Federal Hospital Insurance Trust Fund.

(2) In any case where a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from such Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (c) of this section (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Hospital Insurance Trust Fund, the Managing Trustee determines that the Hospital Insurance Trust Fund ratio exceeds 15 percent, he shall transfer from such Trust Fund to the lending trust fund an amount that—

(I) together with any amounts transferred to another lending trust fund under this paragraph for such year, will reduce the Hospital Insurance Trust Fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term "Hospital Insurance Trust Fund ratio" means, with respect to any calendar year, the ratio of—

(I) the balance in the Federal Hospital Insurance Trust Fund, as of the last day of such calendar year; to

(II) the amount estimated by the Secretary to be the total amount to be paid from the Federal Hospital Insurance Trust Fund during the calendar year following such calendar year (other than payments of interest on, and repayments of, loans from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under paragraph (1)), and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from the Railroad Retirement Account.

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987 and before January 1, 1990, the Managing Trustee shall transfer each month from the Federal Hospital Insurance Trust Fund to any Trust Fund that is owed any amount by the Federal Hospital Insurance Trust Fund on a loan made under paragraph (1), an amount not less than an amount equal to (I) the amount owed to such Trust Fund by the Federal Hospital Insurance Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be loaned by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund under paragraph (1) during any month if the OASDI trust fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "OASDI trust fund ratio" means, with respect to any month, the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Trust Fund from the Federal Hospital Insurance Trust Fund under section 401(l) of this title, as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the month for which such ratio is to be determined for all purposes authorized by section 401 of this title (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 401(l) of this title), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account.

(k) Health Care Fraud and Abuse Control Account

(1) Establishment

There is hereby established in the Trust Fund an expenditure account to be known as the "Health Care Fraud and Abuse Control Account" (in this subsection referred to as the "Account").

(2) Appropriated amounts to Trust Fund

(A) In general

There are hereby appropriated to the Trust Fund—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Insurance Portability and Accountability Act of 1996, and subchapter XI of this chapter; and

(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

(B) Authorization to accept gifts

The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

(C) Transfer of amounts

The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 24(a) of title 18).

(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under this subchapter and subchapters XI and XIX of this chapter, and chapter 38 of title 31 (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31 (known as the False Claims Act), in cases involving claims related to the provision of health care items and

services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

(D) Application

Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.] for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

(3) Appropriated amounts to Account for fraud and abuse control program, etc.

(A) Departments of Health and Human Services and Justice

(i) In general

There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation until expended, in an amount not to exceed—

(I) for fiscal year 1997, \$104,000,000;

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent;

(III) for each of fiscal years 2004, 2005, and 2006, the limit for fiscal year 2003; and

(IV) for each fiscal year after fiscal year 2006, the limit under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(ii) Medicare and medicaid activities

For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the programs under this subchapter and subchapter XIX of this chapter—

(I) for fiscal year 1997, not less than \$60,000,000 and not more than \$70,000,000;

(II) for fiscal year 1998, not less than \$80,000,000 and not more than \$90,000,000;

(III) for fiscal year 1999, not less than \$90,000,000 and not more than \$100,000,000;

(IV) for fiscal year 2000, not less than \$110,000,000 and not more than \$120,000,000;

(V) for fiscal year 2001, not less than \$120,000,000 and not more than \$130,000,000;

(VI) for fiscal year 2002, not less than \$140,000,000 and not more than \$150,000,000;

(VII) for each of fiscal years 2003, 2004, 2005, and 2006, not less than \$150,000,000 and not more than \$160,000,000;

(VIII) for fiscal year 2007, not less than \$160,000,000, increased by the percentage

increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and

(IX) for each fiscal year after fiscal year 2007, not less than the amount required under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(B) Federal Bureau of Investigation

There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation until expended—

(i) for fiscal year 1997, \$47,000,000;

(ii) for fiscal year 1998, \$56,000,000;

(iii) for fiscal year 1999, \$66,000,000;

(iv) for fiscal year 2000, \$76,000,000;

(v) for fiscal year 2001, \$88,000,000;

(vi) for fiscal year 2002, \$101,000,000;

(vii) for each of fiscal years 2003, 2004, 2005, and 2006, \$114,000,000; and

(viii) for each fiscal year after fiscal year 2006, the amount to be appropriated under this subparagraph for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(C) Use of funds

The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1320a-7c(a) of this title, including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of subchapter XI of this chapter.

(4) Appropriated amounts to Account for Medicare Integrity Program

(A) In general

There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary for activities described in paragraph (3)(C) and to carry out the Medicare Integrity Program under section 1395ddd of this title, subject to subparagraphs (B), (C), and (D) and to be available without further appropriation until expended.

(B) Amounts specified

Subject to subparagraph (C), the amount appropriated under subparagraph (A) for a fiscal year is as follows:

(i) For fiscal year 1997, such amount shall be not less than \$430,000,000 and not more than \$440,000,000.

(ii) For fiscal year 1998, such amount shall be not less than \$490,000,000 and not more than \$500,000,000.

(iii) For fiscal year 1999, such amount shall be not less than \$550,000,000 and not more than \$560,000,000.

(iv) For fiscal year 2000, such amount shall be not less than \$620,000,000 and not more than \$630,000,000.

(v) For fiscal year 2001, such amount shall be not less than \$670,000,000 and not more than \$680,000,000.

(vi) For fiscal year 2002, such amount shall be not less than \$690,000,000 and not more than \$700,000,000.

(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than \$710,000,000 and not more than \$720,000,000.

(C) Adjustments

The amount appropriated under subparagraph (A) for a fiscal year is increased as follows:

(i) For fiscal year 2006, \$100,000,000.

(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(D) Expansion of the Medicare-Medicaid Data Match Program

The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1395ddd(b)(6) of this title for the respective fiscal year:

(i) \$12,000,000 for fiscal year 2006.

(ii) \$24,000,000 for fiscal year 2007.

(iii) \$36,000,000 for fiscal year 2008.

(iv) \$48,000,000 for fiscal year 2009.

(v) \$60,000,000 for fiscal year 2010 and each fiscal year thereafter.

(5) Annual report

Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress which identifies—

(A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and

(B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

(6) GAO report

Not later than June 1, 1998, and January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

(A) identifies—

(i) the amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

(ii) the amounts appropriated from the Trust Fund for such fiscal years under

paragraph (3) and the justification for the expenditure of such amounts;

(B) identifies any expenditures from the Trust Fund with respect to activities not involving the program under this subchapter;

(C) identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

(D) analyzes such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.

(7) Additional funding

In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional \$10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

(8) Additional funding

(A) In general

In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3)(C) and (4)(A) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated to such Account from such Trust Fund the following additional amounts:

(i) For fiscal year 2011, \$95,000,000.

(ii) For fiscal year 2012, \$55,000,000.

(iii) For each of fiscal years 2013 and 2014, \$30,000,000.

(iv) For each of fiscal years 2015 and 2016, \$20,000,000.

(B) Allocation

The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1817, as added Pub. L. 89-97, title I, § 102(a), July 30, 1965, 79 Stat. 299; amended Pub. L. 90-248, title I, § 169(a), Jan. 2, 1968, 81 Stat. 875; Pub. L. 92-603, title I, § 132(d), Oct. 30, 1972, 86 Stat. 1361; Pub. L. 95-292, § 5, June 13, 1978, 92 Stat. 315; Pub. L. 96-265, title III, § 310(c), June 9, 1980, 94 Stat. 460; Pub. L. 97-123, § 1(b), Dec. 29, 1981, 95 Stat. 1659; Pub. L. 98-21, title I, §§ 141(b), 142(b)(1), (2)(A), (3), (4), 154(b), title III, § 341(b), Apr. 20, 1983, 97 Stat. 98, 100, 101, 107, 135; Pub. L. 98-369, div. B, title III, §§ 2337(a), 2354(b)(2), title VI, § 2663(j)(2)(F)(i), July 18, 1984, 98 Stat. 1091, 1100, 1170; Pub. L. 99-272, title IX, § 9213(b), Apr. 7, 1986, 100 Stat. 180; Pub. L. 99-514, § 2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100-360, title II, § 212(c)(3), July 1, 1988, 102 Stat. 741; Pub. L. 100-647, title VIII, § 8005(a), Nov. 10, 1988, 102 Stat. 3781; Pub. L. 101-234, title

II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101-508, title V, §5106(c), Nov. 5, 1990, 104 Stat. 1388-268; Pub. L. 103-296, title I, §108(c)(1), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 104-191, title II, §201(b), Aug. 21, 1996, 110 Stat. 1993; Pub. L. 105-33, title IV, §4318, Aug. 5, 1997, 111 Stat. 392; Pub. L. 106-113, div. B, §1000(a)(6) [title III, §321(j)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A-366; Pub. L. 108-173, title VII, §736(a)(5), (6), title VIII, §801(d)(1), title IX, §900(e)(1)(D), Dec. 8, 2003, 117 Stat. 2355, 2359, 2371; Pub. L. 109-171, title V, §5204, title VI, §6034(d)(2), Feb. 8, 2006, 120 Stat. 48, 78; Pub. L. 109-432, div. B, title III, §303, Dec. 20, 2006, 120 Stat. 2992; Pub. L. 111-148, title VI, §6402(i), Mar. 23, 2010, 124 Stat. 760; Pub. L. 111-152, title I, §1303(a)(1), Mar. 30, 2010, 124 Stat. 1057.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(1), (2), (f)(1), and (k)(2)(C), is classified generally to Title 26, Internal Revenue Code. Subtitle F of such Code appears at section 6001 et seq. of Title 26.

Section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(2), is section 801(a) of Pub. L. 108-173, which is set out as a note under this section.

Sections 242(b) and 249(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (k)(2)(A)(ii), are sections 242(b) and 249(b) of Pub. L. 104-191, which are set out as notes under this section.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (k)(2)(D), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 832, as amended. Title I of the Act is classified generally to subchapter I (§1001 et seq.) of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

AMENDMENTS

2010—Subsec. (k)(3)(A)(i)(III). Pub. L. 111-148, §6402(i)(2)(A)(i), inserted “and” at the end.

Subsec. (k)(3)(A)(i)(IV). Pub. L. 111-148, §6402(i)(2)(A)(ii), substituted “for each fiscal year after fiscal year 2006” for “for each of fiscal years 2007, 2008, 2009, and 2010” and a period for “; and”.

Subsec. (k)(3)(A)(i)(V). Pub. L. 111-148, §6402(i)(2)(A)(iii), struck out subcl. (V) which read as follows: “for each fiscal year after fiscal year 2010, the limit under this clause for fiscal year 2010.”

Subsec. (k)(3)(A)(ii)(VIII). Pub. L. 111-148, §6402(i)(2)(B)(i), inserted “and” at the end.

Subsec. (k)(3)(A)(ii)(IX). Pub. L. 111-148, §6402(i)(2)(B)(ii), substituted “for each fiscal year after fiscal year 2007” for “for each of fiscal years 2008, 2009, and 2010” and a period for “; and”.

Subsec. (k)(3)(A)(ii)(X). Pub. L. 111-148, §6402(i)(2)(B)(iii), struck out subcl. (X) which read as follows: “for each fiscal year after fiscal year 2010, not less than the amount required under this clause for fiscal year 2010.”

Subsec. (k)(3)(B)(vii). Pub. L. 111-148, §6402(i)(2)(C)(i), inserted “and” at the end.

Subsec. (k)(3)(B)(viii). Pub. L. 111-148, §6402(i)(2)(C)(ii), substituted “for each fiscal year after fiscal year 2006” for “for each of fiscal years 2007, 2008, 2009, and 2010” and a period for “; and”.

Subsec. (k)(3)(B)(ix). Pub. L. 111-148, §6402(i)(2)(C)(iii), struck out cl. (ix) which read as follows: “for each fiscal year after fiscal year 2010, the amount to be appropriated under this subparagraph for fiscal year 2010.”

Subsec. (k)(4)(A). Pub. L. 111-152, §1303(a)(1)(B), inserted “for activities described in paragraph (3)(C) and” after “necessary”.

Pub. L. 111-148, §6402(i)(1)(B), inserted “until expended” after “appropriation”.

Subsec. (k)(4)(C)(ii). Pub. L. 111-148, §6402(i)(2)(D), added cl. (ii).

Subsec. (k)(7). Pub. L. 111-148, §6402(i)(1)(A), added par. (7).

Subsec. (k)(8). Pub. L. 111-152, §1303(a)(1)(A), added par. (8).

2006—Subsec. (k)(3)(A)(i). Pub. L. 109-432, §303(a)(1), in introductory provisions inserted “until expended” after “without further appropriation”, in subcl. (II) struck out “and” at end, in subcl. (III) substituted “for each of fiscal years 2004, 2005, and 2006” for “for each fiscal year after fiscal year 2003” and semicolon for period at end, and added subcls. (IV) and (V).

Subsec. (k)(3)(A)(ii)(VI) to (X). Pub. L. 109-432, §303(a)(2), in subcl. (VI) struck out “and” at end, in subcl. (VII) substituted “for each of fiscal years 2003, 2004, 2005, and 2006” for “for each fiscal year after fiscal year 2002” and semicolon for period at end, and added subcls. (VIII) to (X).

Subsec. (k)(3)(B). Pub. L. 109-432, §303(b), in introductory provisions inserted “until expended” after “with-out further appropriation”, in cl. (vi) struck out “and” at end, in cl. (vii) substituted “for each of fiscal years 2003, 2004, 2005, and 2006” for “for each fiscal year after fiscal year 2002” and semicolon for period at end, and added cls. (viii) and (ix).

Subsec. (k)(4)(A). Pub. L. 109-171, §6034(d)(2)(A), substituted “subparagraphs (B), (C), and (D)” for “subparagraph (B)”.

Subsec. (k)(4)(B). Pub. L. 109-171, §5204(1), substituted “Subject to subparagraph (C), the amount” for “The amount” in introductory provisions.

Subsec. (k)(4)(C). Pub. L. 109-171, §5204(2), added subpar. (C).

Subsec. (k)(4)(D). Pub. L. 109-171, §6034(d)(2)(B), added subpar. (D).

2003—Subsec. (b). Pub. L. 108-173, §900(e)(1)(D), in fifth sentence of introductory provisions, substituted “Centers for Medicare & Medicaid Services” for “Health Care Financing Administration”, and, in second sentence of concluding provisions, substituted “Chief Actuary of the Centers for Medicare & Medicaid Services” for “Chief Actuarial Officer of the Health Care Financing Administration”.

Subsec. (b)(2). Pub. L. 108-173, §801(d)(1), inserted at end “Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.”

Subsec. (k)(3)(A)(i)(I). Pub. L. 108-173, §736(a)(5)(A), substituted semicolon for comma at end.

Subsec. (k)(3)(A)(ii). Pub. L. 108-173, §736(a)(5)(B), substituted “the programs under this subchapter and subchapter XIX of this chapter” for “the Medicare and medicaid programs” in introductory provisions.

Subsec. (k)(6)(B). Pub. L. 108-173, §736(a)(6), substituted “program under this subchapter” for “Medicare program under this subchapter”.

1999—Subsec. (k)(2)(C)(i). Pub. L. 106-113 substituted “section 24(a)” for “section 982(a)(6)(B)”.

1997—Subsec. (k)(6). Pub. L. 105-33 inserted “June 1, 1998, and” after “Not later than” in introductory provisions.

1996—Subsec. (k). Pub. L. 104-191 added subsec. (k).

1994—Subsec. (a). Pub. L. 103-296, §108(c)(1)(A), substituted “Commissioner of Social Security” for “Secretary of Health and Human Services” wherever appearing.

Subsec. (b). Pub. L. 103-296, §108(c)(1)(B), inserted “the Commissioner of Social Security,” after “composed of” in introductory provisions.

Subsec. (f)(1). Pub. L. 103-296, §108(c)(1)(C), substituted “Commissioner of Social Security” for “Secretary of Health and Human Services” in two places.

1990—Subsec. (i). Pub. L. 101-508 inserted at end “The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount al-

lowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.”

1989—Subsec. (b). Pub. L. 101-234 repealed Pub. L. 100-360, §212(c)(3), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (b). Pub. L. 100-647 inserted after first sentence “A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member’s term until the earlier of the time at which the member’s successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member’s term.”

Pub. L. 100-360 inserted after sixth sentence “Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1395t-2 of this title and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.”

1986—Subsec. (a)(1), (2). Pub. L. 99-514 substituted “Internal Revenue Code of 1986” for “Internal Revenue Code of 1954”.

Subsec. (b). Pub. L. 99-272 struck out provision at end of penultimate sentence that certification shall not refer to economic assumptions underlying Trustee’s report.

Subsec. (f)(1). Pub. L. 99-514 substituted “Internal Revenue Code of 1986” for “Internal Revenue Code of 1954” wherever appearing.

1984—Subsec. (a). Pub. L. 98-369, §2337(a), in provisions following par. (2) substituted “from time to time” for “monthly on the first day of each calendar month”, “paid to or deposited into the Treasury” for “to be paid to or deposited into the Treasury during such month”, and struck out provision that all amounts transferred to the Trust Fund under the preceding sentence had to be invested by the Managing Trustee in the same manner and to the same extent as the other assets of the Trust Fund, and the Trust Fund had to pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on January 1, 1983) equal to the rate earned by the investments of the Trust Fund in the same month under subsec. (c).

Subsec. (a)(1), (2). Pub. L. 98-369, §2663(j)(2)(F)(i), substituted “Health and Human Services” for “Health, Education, and Welfare” wherever appearing.

Subsec. (c). Pub. L. 98-369, §2354(b)(2), substituted “under chapter 31 of title 31” for “under the Second Liberty Bond Act, as amended”.

Subsecs. (f)(1), (g), (h). Pub. L. 98-369, §2663(j)(2)(F)(i), substituted “Health and Human Services” for “Health, Education, and Welfare” wherever appearing.

1983—Subsec. (a). Pub. L. 98-21, §141(b)(1)(A), in provisions following par. (2) substituted “monthly on the first day of each calendar month” for “from time to time”, substituted “to be paid to or deposited into the Treasury during such month” for “paid to or deposited into the Treasury”, and inserted provision that all amounts transferred to the Trust Fund under existing provisions shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of the Trust Fund; and the Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first

day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on Jan. 1, 1983) equal to the rate earned by the investments of the Trust Fund in the same month under subsection (c).

Subsec. (b). Pub. L. 98-21, §341(b)(1), substituted in provisions preceding par. (1) “Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate” for “Secretary of Health, Education, and Welfare, all ex officio”.

Pub. L. 98-21, §154(b), inserted at end provision that the report referred to in par. (2) shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable and provided further that the certification shall not refer to economic assumptions underlying the Trustee’s report.

Pub. L. 98-21, §341(b)(2), inserted at end provision that a person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

Subsec. (j)(1). Pub. L. 98-21, §142(b)(1), substituted reference to January 1988 for reference to January 1983 and inserted “, subject to paragraph (5),” after “may”.

Subsec. (j)(2). Pub. L. 98-21, §142(b)(2)(A), substituted “on the last day of each month after such loan is made” for “from time to time”, substituted “the total interest accrued to such day” for “interest”, and inserted “(even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan)”.

Subsec. (j)(3)(A). Pub. L. 98-21, §142(b)(3), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j)(5). Pub. L. 98-21, §142(b)(4), added par. (5).

1981—Subsec. (j). Pub. L. 97-123 added subsec. (j).

1980—Subsec. (i). Pub. L. 96-265 added subsec. (i).

1978—Subsec. (b). Pub. L. 95-292 substituted “Administrator of the Health Care Financing Administration” for “Commissioner of Social Security” in provisions preceding par. (1).

1972—Subsec. (a). Pub. L. 92-603 inserted “such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and” after “consist of” and before “such amounts” in provisions preceding par. (1).

1968—Subsec. (b)(2). Pub. L. 90-248 substituted “April” for “March”.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106-113, div. B, §1000(a)(6) [title III, §321(j)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-366, provided that: “The amendment made by this subsection [amending this section] shall take effect as if included in the amendment made by section 201 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 1992).”

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103-296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103-296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101-508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d) of Pub. L. 101-508, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101-234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 100-234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100-647 applicable to members of Board of Trustees of Federal Hospital Insurance Trust Fund serving on such Board as members of the public on or after Nov. 10, 1988, see section 8005(b) of Pub. L. 100-647, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98-369, div. B, title III, §2337(b), July 18, 1984, 98 Stat. 1091, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the first day of the month following the month in which this Act is enacted [July 1984]."

Amendment by section 2354(b)(2) of Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98-369, set out as a note under section 1320a-1 of this title.

Amendment by section 2663(j)(2)(F)(i) of Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98-369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 141(b) of Pub. L. 98-21 effective on first day of month following April 1983, see section 141(c) of Pub. L. 98-21, set out as a note under section 401 of this title.

Pub. L. 98-21, title I, §142(b)(2)(B), Apr. 20, 1983, 97 Stat. 101, provided that: "The amendment made by this paragraph [amending this section] shall apply with respect to months beginning more than 30 days after the date of enactment of this Act [Apr. 20, 1983]."

Amendment by sections 154(b) and 341(b) of Pub. L. 98-21 effective Apr. 20, 1983, see sections 154(e) and 341(d) of Pub. L. 98-21, set out as notes under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97-123 effective Dec. 29, 1981, see section 1(c) of Pub. L. 97-123, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95-292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95-292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92-603 applicable with respect to gifts and bequests received after Oct. 30, 1972, see section 132(f) of Pub. L. 92-603, set out as a note under section 401 of this title.

RESTORATION OF MEDICARE TRUST FUNDS

Pub. L. 108-173, title VII, §734, Dec. 8, 2003, 117 Stat. 2352, provided that:

"(a) DEFINITIONS.—In this section:

"(1) CLERICAL ERROR.—The term 'clerical error' means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to a Trust Fund.

"(2) TRUST FUND.—The term 'Trust Fund' means the Federal Hospital Insurance Trust Fund established

under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

"(b) CORRECTION OF TRUST FUND HOLDINGS.—

"(1) IN GENERAL.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary [of Health and Human Services], the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

"(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

"(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

"(i) would have been issued to the Trust Fund if the clerical error involved had not occurred; or

"(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error involved; and

"(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error involved had not occurred.

"(c) APPROPRIATION.—There is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error involved.

"(d) CONGRESSIONAL NOTICE.—In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury, before taking action to correct the error under this section, shall notify the appropriate committees of Congress concerning such error and the actions to be taken under this section in response to such error.

"(e) DEADLINE.—With respect to the clerical error that occurred on April 15, 2001, not later than 120 days after the date of the enactment of this Act [Dec. 8, 2003]—

"(1) the Secretary of the Treasury shall take the actions under subsection (b)(1); and

"(2) the appropriation under subsection (c) shall be made."

INCLUSION IN ANNUAL REPORT OF MEDICARE TRUSTEES OF INFORMATION ON STATUS OF MEDICARE TRUST FUNDS

Pub. L. 108-173, title VIII, §801, Dec. 8, 2003, 117 Stat. 2357, provided that:

"(a) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

"(1) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

"(A) the information described in subsection (b); and

"(B) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in subsection (c)) for the fiscal year in which the report is submitted or for any of the succeeding 6 fiscal years.

"(2) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subtitle [subtitle A (§§801-804) of title VIII of Pub. L. 108-173, amending this section, section 1395t of this title, and section 1105 of Title 31, Money and Finance, and enacting provisions set out as a note under section 1105 of Title 31], an affirmative determination under paragraph (1)(B) in 2 consecutive an-

nual reports shall be treated as a medicare funding warning in the year in which the second such report is made.

“(3) 7-FISCAL-YEAR REPORTING PERIOD.—For purposes of this subtitle, the term ‘7-fiscal-year reporting period’ means, with respect to a year in which an annual report described in paragraph (1) is made, the period of 7 consecutive fiscal years beginning with the fiscal year in which the report is submitted.

“(b) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

“(1) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

“(A) Each fiscal year within the 7-fiscal-year reporting period.

“(B) Previous fiscal years and as of 10, 50, and 75 years after such year.

“(2) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

“(A) The gross domestic product.

“(B) Private health costs.

“(C) National health expenditures.

“(D) Other appropriate measures.

“(3) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w-101 et seq.], as added by section 101.

“(4) COMBINED MEDICARE TRUST FUND ANALYSIS.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in subsection (c)(1)(B) of total medicare outlays.

“(c) DEFINITIONS.—For purposes of this section:

“(1) EXCESS GENERAL REVENUE MEDICARE FUNDING.—The term ‘excess general revenue medicare funding’ means, with respect to a fiscal year, that—

“(A) general revenue medicare funding (as defined in paragraph (2)), expressed as a percentage of total medicare outlays (as defined in paragraph (4)) for the fiscal year; exceeds

“(B) 45 percent.

“(2) GENERAL REVENUE MEDICARE FUNDING.—The term ‘general revenue medicare funding’ means for a year—

“(A) the total medicare outlays (as defined in paragraph (4)) for the year; minus

“(B) the dedicated medicare financing sources (as defined in paragraph (3)) for the year.

“(3) DEDICATED MEDICARE FINANCING SOURCES.—The term ‘dedicated medicare financing sources’ means the following:

“(A) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

“(B) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98-21) [set out as a note under section 401 of this title], as inserted by section 13215(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66).

“(C) STATE TRANSFERS.—The State share of amounts paid to the Federal Government by a State under section 1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(c) of such Act [42 U.S.C. 1396u-5(c)].

“(D) PREMIUMS.—The following premiums:

“(i) PART A.—Premiums paid by non-Federal sources under sections 1818 and section [sic] 1818A (42 U.S.C. 1395i-2 and 1395i-2a) of such Act.

“(ii) PART B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

“(iii) PART D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act [42 U.S.C. 1395w-101 et seq.], as added by section 101, and MA monthly prescription drug beneficiary premiums paid under part C of such title [42 U.S.C. 1395w-21 et seq.] insofar as they are attributable to basic prescription drug coverage.

Premiums under clauses (ii) and (iii) shall be determined without regard to any reduction in such premiums attributable to a beneficiary rebate under section 1854(b)(1)(C) of such title [42 U.S.C. 1395w-24(b)(1)(C)], as amended by section 222(b)(1), and premiums under clause (iii) are deemed to include any amounts paid under section 1860D-13(b) of such title [42 U.S.C. 1395w-113(b)], as added by section 101.

“(E) GIFTS.—Amounts received by the medicare trust funds under section 201(i) of the Social Security Act (42 U.S.C. 401(i)).

“(4) TOTAL MEDICARE OUTLAYS.—The term ‘total medicare outlays’ means total outlays from the medicare trust funds and shall—

“(A) include payments made to plans under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.] that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w-24(b)(1)(C)), as amended by section 222(b)(1);

“(B) include administrative expenditures made in carrying out title XVIII of such Act [42 U.S.C. 1395 et seq.] and Federal outlays under section 1935(b) of such Act [42 U.S.C. 1396u-5(b)], as added by section 103(a)(2); and

“(C) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

“(5) MEDICARE TRUST FUND.—The term ‘medicare trust fund’ means—

“(A) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

“(B) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

“(d) CONFORMING AMENDMENTS.—

“(1) FEDERAL HOSPITAL INSURANCE TRUST FUND [Amended section 1395i of this title].

“(2) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND [Amended section 1395t of this title].

“(e) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for any fiscal year within the 7-fiscal-year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures.”

CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND

Pub. L. 104-191, title II, §242(b), Aug. 21, 1996, 110 Stat. 2016, provided that: “The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).”

PROPERTY FORFEITTED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND

Pub. L. 104-191, title II, §249(c), Aug. 21, 1996, 110 Stat. 2020, provided that:

“(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made and after all restoration payments (if any) have been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act [42 U.S.C. 1395i(k)(2)(C)], as added by section 301(b), an amount equal to the net amount

realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

“(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term ‘payment of the costs of asset forfeiture’ means—

“(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

“(i) contract services;

“(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

“(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

“(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

“(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

“(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

“(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

“(3) RESTORATION PAYMENT.—Notwithstanding any other provision of law, if the Federal health care offense referred to in paragraph (1) resulted in a loss to an employee welfare benefit plan within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)], the Secretary of the Treasury shall transfer to such employee welfare benefit plan, from the amount realized from the forfeiture of property referred to in paragraph (1), an amount equal to such loss. For purposes of paragraph (1), the term ‘restoration payment’ means the amount transferred to an employee welfare benefit plan pursuant to this paragraph.”

DUE DATE FOR 1983 REPORT ON OPERATION AND STATUS OF TRUST FUND

Notwithstanding subsec. (b)(2) of this section, the annual report of the Board of Trustees of the Trust Fund required for calendar year 1983 under this section may be filed at any time not later than forty-five days after Apr. 20, 1983, see section 154(d) of Pub. L. 98-21, set out as a note under section 401 of this title.

§ 1395i-1. Authorization of appropriations

There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1395i of this title) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under this part with respect to individuals who are qualified railroad retirement beneficiaries (as defined in section 426(c)¹ of this title) and who

are not, and upon filing application for monthly insurance benefits under section 402 of this title would not be, entitled to such benefits if service as an employee (as defined in the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] after December 31, 1936, had been included in the term “employment” as defined in this chapter,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss of interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the individuals described in paragraph (1) had not been entitled to benefits under this part.

(Pub. L. 89-97, title I, §111(d), July 30, 1965, 79 Stat. 343.)

REFERENCES IN TEXT

Section 426(c) of this title, referred to in par. (1), was redesignated section 426(d) of this title by Pub. L. 92-603, title II, §201(b)(5), Oct. 30, 1972, 86 Stat. 1372.

The Railroad Retirement Act of 1937, referred to in par. (1), is act Aug. 29, 1935, ch. 812, 49 Stat. 867, as amended generally by act June 24, 1937, ch. 382, part I, 50 Stat. 307, and which was classified principally to subchapter III (§228a et seq.) of chapter 9 of Title 45, Railroads. The Railroad Retirement Act of 1937 was amended generally and redesignated the Railroad Retirement Act of 1974 by Pub. L. 93-445, title I, Oct. 16, 1974, 88 Stat. 1305. The Railroad Retirement Act of 1974 is classified generally to subchapter IV (§231 et seq.) of chapter 9 of title 45. For complete classification of these Acts to the Code, see Tables.

CODIFICATION

Section was enacted as part of the Social Security Amendments of 1965 and also as part of the Health Insurance for the Aged Act, and not as part of the Social Security Act which comprises this chapter.

EFFECTIVE DATE

Pub. L. 89-97, title I, §111(e), July 30, 1965, 79 Stat. 343, provided that:

“(1) The amendments made by the preceding provisions of this section [enacting this section and section 228s-2 of Title 45, Railroads, and amending section 1395kk of this title and sections 1401, 3101, 3111, 3201, 3211, and 3221 of Title 26, Internal Revenue Code, and section 228e of Title 45] shall apply to the calendar year 1966 or to any subsequent calendar year, but only if the requirement in paragraph (2) has been met with respect to such calendar year.

“(2) The requirement referred to in paragraph (1) shall be deemed to have been met with respect to any calendar year if, as of the October 1 immediately preceding such calendar year, the Railroad Retirement Tax Act [section 3101 et seq. of Title 26] provides that the maximum amount of monthly compensation taxable under such Act during all months of such calendar year will be an amount equal to one-twelfth of the maximum wages which the Federal Insurance Contributions Act [section 3201 et seq. of Title 26] provides may be counted for such calendar year.”

§ 1395i-1a. Repealed. Pub. L. 101-234, title I, § 102(a), Dec. 13, 1989, 103 Stat. 1980

Section, act Aug. 14, 1935, ch. 531, title XVIII, §1817A, as added July 1, 1988, Pub. L. 100-360, title I, §112(a), 102 Stat. 698, provided for establishment and operation of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.

¹ See References in Text note below.

EFFECTIVE DATE OF REPEAL

Repeal effective Jan. 1, 1990, see section 102(d)(1) of Pub. L. 101-234, set out as a note under section 59B of Title 26, Internal Revenue Code.

ADJUSTMENTS FOR INTEREST LOST DUE TO DELAY OF TRANSFERS TO RESERVE FUND DURING 1989

Pub. L. 100-360, title I, §112(b), July 1, 1988, 102 Stat. 699, which directed Secretary of the Treasury, in July of 1990, to calculate interest lost to Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to lag between outlays (attributable to amendments made by Pub. L. 100-360) from Federal Hospital Insurance Trust Fund during 1989 and transfers made to such Reserve Fund to cover such outlays, and provided that appropriations under subsection (a)(2) of this section include amount so calculated, was repealed by Pub. L. 101-234, title I, §102(a), Dec. 13, 1989, 103 Stat. 1980.

§ 1395i-2. Hospital insurance benefits for uninsured elderly individuals not otherwise eligible

(a) Individuals eligible to enroll

Every individual who—

- (1) has attained the age of 65,
- (2) is enrolled under part B of this subchapter,
- (3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and
- (4) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part. Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1395i-2a of this title.

(b) Time, manner, and form of enrollment

An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(c) Period of enrollment; scope of coverage

The provisions of section 1395p of this title (except subsection (f) thereof), section 1395q of this title, subsection (b) of section 1395r of this title, and subsections (f) and (h) of section 1395s of this title shall apply to persons authorized to enroll under this section except that—

- (1) individuals who meet the conditions of subsection (a)(1), (3), and (4) of this section on or before the last day of the seventh month after October 1972 may enroll under this part and (if not already so enrolled) may also enroll under part B of this subchapter during an initial general enrollment period which shall begin on the first day of the second month which begins after October 30, 1972, and shall end on the last day of the tenth month after October 1972;
- (2) in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth

month after October 1972, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;

(3) in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—

- (A) the first day of the second month after the month in which he enrolls,
- (B) July 1, 1973, or
- (C) the first day of the first month in which he meets the requirements of subsection (a) of this section,

whichever is the latest;

(4) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 426 of this title or section 426a of this title; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement;

(5) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this chapter;

(6) any percent increase effected under section 1395r(b) of this title in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section and shall be subject to reduction in accordance with subsection (d)(6) of this section;

(7) an individual who meets the conditions of subsection (a) of this section may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1395mm of this title with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;

(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

- (A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1395mm of this title with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or
- (B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and

(9) in applying the provisions of section 1395r(b) of this title, there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1395mm of this title with an eligible organization.

(d) Monthly premiums

(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that year.

(2) The Secretary shall, during September of each year¹ determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Subject to paragraphs (4) and (5), the amount of an individual's monthly premium under this section shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not a multiple of \$1, to the next higher multiple of \$1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

(4)(A) In the case of an individual described in subparagraph (B), the monthly premium for a month shall be reduced by the applicable reduction percent specified in the following table:

For a month in:	The applicable reduction percent is:
1994	25 percent
1995	30 percent
1996	35 percent
1997	40 percent
1998 or subsequent year	45 percent.

(B) An individual described in this subparagraph with respect to a month is an individual who establishes to the satisfaction of the Secretary that, as of the last day of the previous month, the individual—

- (i) had at least 30 quarters of coverage under subchapter II of this chapter;
- (ii) was married (and had been married for the previous 1-year period) to an individual who had at least 30 quarters of coverage under such subchapter;
- (iii) had been married to an individual for a period of at least 1 year (at the time of such individual's death) if at such time the individual had at least 30 quarters of coverage under such subchapter; or
- (iv) is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if at such time the individual had at least 30 quarters of coverage under such subchapter.

(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under subchapter XIX of this chapter or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

(ii) in each of 84 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under subchapter XIX of this chapter or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under subchapter II of this chapter if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 410(p) of this title, but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 413 of this title;

(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

(C) For purposes of subparagraph (B)(i)(I), the term "qualified State or local government retirement system" means a retirement system that—

(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

¹ So in original. Probably should be followed by a comma.

(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.

(6)(A) In the case where a State, a political subdivision of a State, or an agency or instrumentality of a State or political subdivision thereof determines to pay, for the life of each individual, the monthly premiums due under paragraph (1) on behalf of each of the individuals in a qualified State or local government retiree group who meets the conditions of subsection (a) of this section, the amount of any increase otherwise applicable under section 1395r(b) of this title (as applied and modified by subsection (c)(6) of this section) with respect to the monthly premium for benefits under this part for an individual who is a member of such group shall be reduced by the total amount of taxes paid under section 3101(b) of the Internal Revenue Code of 1986 by such individual and under section 3111(b) of such Code by the employers of such individual on behalf of such individual with respect to employment (as defined in section 3121(b) of such Code).

(B) For purposes of this paragraph, the term “qualified State or local government retiree group” means all of the individuals who retire prior to a specified date that is before January 1, 2002, from employment in one or more occupations or other broad classes of employees of—

- (i) the State;
- (ii) a political subdivision of the State; or
- (iii) an agency or instrumentality of the State or political subdivision of the State.

(e) Contract or other arrangement for payment of monthly premiums

Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) of this section may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Deposit of amounts into Treasury

Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(g) Buy-in under this part for qualified medicare beneficiaries

(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1395v(a) of this title under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title).

(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1395v of this title shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same

extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B of this subchapter.

(B) For purposes of this subsection, section 1395v(d)(1) of this title shall be applied by substituting “section 1395i-2 of this title” for “section 1395r of this title” and “subsection (c)(6) (with reference to subsection (b) of section 1395r of this title)” for “subsection (b)”.

(Aug. 14, 1935, ch. 531, title XVIII, § 1818, as added Pub. L. 92-603, title II, § 202, Oct. 30, 1972, 86 Stat. 1374; amended Pub. L. 98-21, title VI, § 606(a)(3)(D), (b), Apr. 20, 1983, 97 Stat. 170, 171; Pub. L. 98-369, div. B, title III, §§ 2315(e), 2354(b)(3), (4), July 18, 1984, 98 Stat. 1080, 1100; Pub. L. 99-272, title IX, § 9124(a), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100-203, title IV, § 4009(j)(9), Dec. 22, 1987, as added Pub. L. 100-360, title IV, § 411(b)(8)(D), July 1, 1988, 102 Stat. 772; Pub. L. 100-360, title I, § 103, July 1, 1988, 102 Stat. 687; Pub. L. 100-485, title VI, § 608(d)(2), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101-239, title VI, §§ 6012(a)(1), 6013(a), Dec. 19, 1989, 103 Stat. 2161, 2163; Pub. L. 101-508, title IV, § 4008(g)(1), (m)(3)(D), Nov. 5, 1990, 104 Stat. 1388-45, 1388-54; Pub. L. 103-66, title XIII, § 13508(a), Aug. 10, 1993, 107 Stat. 579; Pub. L. 105-33, title IV, § 4453(a), Aug. 5, 1997, 111 Stat. 425; Pub. L. 106-554, § 1(a)(6) [title III, § 331(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-502; Pub. L. 108-173, title I, § 101(e)(5), title VII, § 736(a)(7), Dec. 8, 2003, 117 Stat. 2151, 2355.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (d)(6)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2003—Subsec. (a). Pub. L. 108-173, § 101(e)(5), inserted at end of concluding provisions “Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1395i-2a of this title.”

Subsec. (d)(6)(A). Pub. L. 108-173, § 736(a)(7)(A), inserted “of such Code” after “3111(b)”.

Subsec. (g)(2)(B). Pub. L. 108-173, § 736(a)(7)(B), substituted “subsection (b)” for “subsection (b).”

2000—Subsec. (c)(6). Pub. L. 106-554, § 1(a)(6) [title III, § 331(a)(1)], inserted “and shall be subject to reduction in accordance with subsection (d)(6) of this section” before semicolon.

Subsec. (d)(6). Pub. L. 106-554, § 1(a)(6) [title III, § 331(a)(2)], added par. (6).

1997—Subsec. (d)(2). Pub. L. 105-33, § 4453(a)(1), substituted “paragraphs (4) and (5)” for “paragraph (4)”.

Subsec. (d)(5). Pub. L. 105-33, § 4453(a)(2), added par. (5).

1993—Subsec. (d)(2). Pub. L. 103-66, § 13508(a)(1), substituted “Subject to paragraph (4), the amount of an individual’s monthly premium under this section” for “Such amount”.

Subsec. (d)(4). Pub. L. 103-66, § 13508(a)(2), added par. (4).

1990—Subsec. (c)(7) to (9). Pub. L. 101-508, § 4008(g)(1), added pars. (7) to (9).

Subsec. (g)(2)(B). Pub. L. 101-508, § 4008(m)(3)(D), substituted “subsection (c)(6)” for “subsection (c)”.

1989—Pub. L. 101-239, § 6012(a)(1), inserted “elderly” after “uninsured” in section catchline.

Subsec. (g). Pub. L. 101-239, § 6013(a), added subsec. (g).

1988—Subsec. (c)(4) to (7). Pub. L. 100-360, § 411(b)(8)(D), added Pub. L. 100-203, § 4009(j)(9), see 1987 Amendment note below.

Subsec. (d). Pub. L. 100-360, § 103, amended subsec. (d) generally. Prior to amendment, subsec. (d) read as follows:

“(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be \$33.

“(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to \$33, multiplied by the ratio of (A) the inpatient hospital deductible for that following calendar year, as promulgated under section 1395e(b)(2) of this title, to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest multiple of \$1, or, if a multiple of 50 cents but not a multiple of \$1, to the next higher multiple of \$1.”

Subsec. (d)(1). Pub. L. 100-485 substituted “during that year” for “during that entire year”.

1987—Subsec. (c)(4) to (7). Pub. L. 100-203, § 4009(j)(9), as added by Pub. L. 100-360, § 411(b)(8)(D), redesignated pars. (5) to (7) as (4) to (6), respectively, and struck out former par. (4) which read as follows: “termination of coverage under this section by the filing of notice that the individual no longer wishes to participate in the hospital insurance program shall take effect at the close of the month following the month in which such notice is filed.”

1986—Subsec. (c)(7). Pub. L. 99-272 added par. (7).

1984—Subsec. (c). Pub. L. 98-369, § 2315(e), substituted “subsection (b) of section 1395r of this title” for “subsection (a) of section 1395r of this title”.

Subsec. (c)(1). Pub. L. 98-369, § 2354(b)(3), substituted “October 1972” for “the month in which this Act is enacted”.

Subsec. (d)(2). Pub. L. 98-369, § 2354(b)(4), substituted “, if a multiple of 50 cents but not a multiple of \$1,” for “if midway between multiples of \$1”.

1983—Subsec. (c). Pub. L. 98-21, § 606(a)(3)(D), substituted “subsection (a) of section 1395r” for “subsection (c) of section 1395r”.

Subsec. (d)(2). Pub. L. 98-21, § 606(b), substituted “during the next to last calendar quarter of each year” for “during the last calendar quarter of each year, beginning in 1973,” “the following calendar year” for “the 12-month period commencing July 1 of the next year”, and “for that following calendar year” for “for such next year”.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, § 1(a)(6) [title III, § 331(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-502, provided that: “The amendments made by subsection (a) [amending this section] shall apply to premiums for months beginning with January 1, 2002.”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-33, title IV, § 4453(b), Aug. 5, 1997, 111 Stat. 426, provided that: “The amendments made by subsection (a) [amending this section] shall apply to premiums for months beginning with January 1998, and months before such month may be taken into account for purposes of meeting the requirement of section 1818(d)(5)(B)(iii) of the Social Security Act [42 U.S.C. 1395i-2(d)(5)(B)(iii)], as added by subsection (a).”

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103-66, title XIII, § 13508(b), Aug. 10, 1993, 107 Stat. 580, provided that: “The amendments made by this section [amending this section] shall apply to monthly premiums under section 1818 of the Social Security Act [42 U.S.C. 1395i-2] for months beginning with January 1, 1994.”

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101-508, title IV, § 4008(g)(2), Nov. 5, 1990, 104 Stat. 1388-46, provided that: “The amendment made by paragraph (1) [amending this section] shall take effect on February 1, 1991.”

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6012(a)(1) of Pub. L. 101-239 effective Dec. 19, 1989, but not applicable so as to provide coverage under this part for any month before July 1990, see section 6012(b) of Pub. L. 101-239, set out as an Effective Date note under section 1395i-2a of this title.

Pub. L. 101-239, title VI, § 6013(c), Dec. 19, 1989, 103 Stat. 2164, provided that: “The amendments made by this section [amending this section and section 1395v of this title] shall become effective January 1, 1990.”

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100-485 effective as if originally included in the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 103 of Pub. L. 100-360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100-360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(b)(8)(D) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99-272, title IX, § 9124(b), Apr. 7, 1986, 100 Stat. 168, provided that:

“(1) The amendment made by subsection (a)(3) [amending this section] shall apply to premiums paid for months beginning with July 1986.

“(2) In applying that amendment, months (before, during, or after April 1986) in which an individual was required to pay a premium increased under the section that was so amended shall be taken into account in determining the month in which the premium will no longer be subject to an increase under that section as so amended.”

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2315(e) of Pub. L. 98-369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98-21, see section 2315(g) of Pub. L. 98-369, set out as an Effective and Termination Dates of 1984 Amendments note under section 1395ww of this title.

Amendment by section 2354(b)(3), (4) of Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98-369, set out as a note under section 1320a-1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98-21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98-21, set out as a note under section 1395r of this title.

SPECIAL ENROLLMENT PROVISIONS FOR MERCHANT SEAMEN

Pub. L. 97-248, title I, § 125, Sept. 3, 1982, 96 Stat. 365, provided that:

“(a) Any individual who—

“(1) was entitled to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect on September 30, 1981), including such entitlement on the basis of continuing medical care under 42 C.F.R. § 32.17, at any time during the period beginning on March 10, 1981, and ending on October 1, 1981, and

“(2) as of September 30, 1981, was eligible under section 1818(a) or section 1836 of the Social Security Act [42 U.S.C. 1395i-2(a), 1395o] to enroll in the insurance program established by part A or part B, respectively, of title XVIII of that Act [42 U.S.C. 1395c et seq., 1395j et seq.] (hereinafter in this section referred to as the ‘respective program’),

may enroll (if not otherwise enrolled) in the respective program during the period beginning on the first day of the first month beginning at least 20 days after the date of the enactment of this Act [Sept. 3, 1982] and ending on December 31, 1982.

“(b)(1) The coverage period under the respective program of an individual who enrolls under subsection (a) shall begin—

“(A) on the first day of the month following the month in which the individual enrolls, or

“(B) on October 1, 1981, if the individual files a request for this subparagraph to apply and pays the monthly premiums for the months so covered.

“(2) The coverage period under the respective program of an individual described in subsection (a) who enrolled in the respective program before the enrollment period described in that subsection shall be retroactively extended to October 1, 1981, if the individual files a request before January 1, 1983, for such retroactive extension and pays the monthly premiums for the months so covered.

“(c)(1) For purposes of section 1839(d) of the Social Security Act [42 U.S.C. 1395r(d)] with respect to the monthly premium for months after September 1981, if an individual described in subsection (a) has enrolled in the insurance program under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] at any time before the end of the enrollment period described in subsection (a), any month (before the end of that enrollment period) in which he was not enrolled in that program shall not be treated as a month in which he could have been enrolled in the program.

“(2) Paragraph (1) shall not apply to an individual—

“(A) if the individual has enrolled in the insurance program before March 10, 1981, unless the enrollment was terminated solely because the individual lost eligibility to be so enrolled, or

“(B) unless the individual applies for the benefit of such paragraph before January 1, 1983.

“(d)(1) The Secretary of Health and Human Services, beginning as soon as possible but not later than 30 days after the date of the enactment of this Act [Sept. 3, 1982], shall provide for the dissemination of information—

“(A) to unions and other associations representing or assisting seamen,

“(B) to offices enrolling individuals under the respective programs, and

“(C) to such other entities and in such a manner as will effectively inform individuals eligible for benefits under this section, concerning the special benefits provided under this section.

“(2) An individual may establish that the individual was entitled at a date to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect before October 1, 1981) by providing—

“(A) documentation relating to the status under which the individual was provided care in (or under arrangements with) a Public Health Service facility on that date,

“(B) the individual’s seamen’s papers covering that date, or

“(C) such other reasonable documentation as the Secretary may require.”

§ 1395i-2a. Hospital insurance benefits for disabled individuals who have exhausted other entitlement

(a) Eligibility

Every individual who—

(1) has not attained the age of 65;

(2)(A) has been entitled to benefits under this part under section 426(b) of this title, and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 416(i)(1) of this title), but

(C) whose entitlement under section 426(b) of this title ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title); and

(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b) Enrollment

(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual’s initial enrollment period shall begin with the month in which the individual receives notice that the individual’s entitlement to benefits under section 426(b) of this title will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

(c) Coverage period

(1) The period (in this subsection referred to as a “coverage period”) during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) of this section before the month in which the individual first satisfies subsection (a) of this section, the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) of this section in the month in which the individual first satisfies subsection (a) of this section, the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) of this section in the month following the month in which the individual first satisfies subsection (a) of this section, the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) of this section more

than one month following the month in which the individual first satisfies subsection (a) of this section, the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3) of this section, the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B) of this section.

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 426(a) or 426-1 of this title.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this subchapter.

(3) The provisions of subsections (h) and (i) of section 1395p of this title apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1395i-2 of this title.

(d) Payment of premiums

(1)(A) Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 426(b) of this title.

(2) The provisions of subsections (d) through (f) of section 1395i-2 of this title (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

(Aug. 14, 1935, ch. 531, title XVIII, §1818A, as added Pub. L. 101-239, title VI, §6012(a)(2), Dec. 19, 1989, 103 Stat. 2161; amended Pub. L. 101-508,

title IV, §4008(m)(3)(C), Nov. 5, 1990, 104 Stat. 1388-54.)

AMENDMENTS

1990—Subsec. (d)(1)(A). Pub. L. 101-508, §4008(m)(3)(C)(i), inserted “for enrollment under this section” after “Premiums”.

Subsec. (d)(1)(C). Pub. L. 101-508, §4008(m)(3)(C)(ii), struck out subpar. (C) which read as follows: “For purposes of applying section 1395r(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1395i-2 of this title shall be deemed to include a reference to this section.”

EFFECTIVE DATE

Pub. L. 101-239, title VI, §6012(b), Dec. 19, 1989, 103 Stat. 2163, provided that: “The amendments made by this section [enacting this section and amending section 1395i-2 of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989], but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for any month before July 1990.”

§ 1395i-3. Requirements for, and assuring quality of care in, skilled nursing facilities

(a) “Skilled nursing facility” defined

In this subchapter, the term “skilled nursing facility” means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(l) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar

as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;

(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 with respect to each assessment.

(III) The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty

under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Subject to the timeframes prescribed by the Secretary under section 1395yy(e)(6) of this title, such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care

(i) In general

Except as provided in clause (ii), a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.

(ii) Exception

To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,

(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physi-

cian to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12)¹ of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this subparagraph shall be subject to annual renewal.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a skilled nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990 for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A) of this section, and

(II) is competent to provide nursing or nursing-related services.

(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A skilled nursing facility must provide, for individuals used as a nurse aide² by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) of this section and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) of this section that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a

¹ See References in Text note below.

² So in original. Probably should be "as nurse aides".

training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program or a new competency evaluation program.

(E) Regular in-service education

The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a skilled nursing facility, but does not include an individual—

- (i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or
- (ii) who volunteers to provide such services without monetary compensation.

Such term includes an individual who provides such services through an agency or under a contract with the facility.

(G) "Licensed health professional" defined

In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician.

(6) Physician supervision and clinical records

A skilled nursing facility must—

- (A) require that the medical care of every resident be provided under the supervision of a physician;
- (B) provide for having a physician available to furnish necessary medical care in case of emergency; and
- (C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

(7) Required social services

In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A skilled nursing facility shall post daily for each shift the current number of licensed

and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A skilled nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

- (I) to ensure the physical safety of the resident or other residents, and
- (II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

- (I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and
- (II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this subchapter) to a portion of the facility that is not such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this subchapter or to medical assistance under subchapter XIX of this chapter.

(B) Notice of rights and services

A skilled nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under section 1396r(e)(6) of this title; and

(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under

this subchapter or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs. In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this subchapter to have access to the services of such a consultant on a timely basis.

(E) Information respecting advance directives

A skilled nursing facility must comply with the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(2) Transfer and discharge rights**(A) In general**

A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XIX of this chapter on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or dis-

charge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3) of this section; and

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]).

(C) Orientation

A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(3) Access and visitation rights

A skilled nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary,

by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this subchapter for all individuals regardless of source of payment.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a skilled nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or under a State plan under subchapter XIX of this chapter, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this subchapter with respect to admissions practices of skilled nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a

contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(6) Protection of resident funds

(A) In general

The skilled nursing facility—

- (i) may not require residents to deposit their personal funds with the facility, and
- (ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of \$100 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits³ all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XIX of this chapter.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5) of this section).

(B) Required notices

If a change occurs in—

- (i) the persons with an ownership or control interest (as defined in section 1320a-3(a)(3) of this title) in the facility,
- (ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a-5(b) of this title) of the facility,
- (iii) the corporation, association, or other company responsible for the management of the facility, or
- (iv) the individual who is the administrator or director of nursing of the facility,

the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C)⁴ Skilled nursing facility administrator

The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4) of this section.

(C)⁴ Availability of survey, certification, and complaint investigation reports

A skilled nursing facility must—

- (i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and
- (ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) Licensing and Life Safety Code

(A) Licensing

A skilled nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

³So in original. Probably should be "credit".

⁴So in original. Two subpars. (C) have been enacted. See Amendment of Subsection (d)(1) note below.

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

(3) Sanitary and infection control and physical environment

A skilled nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a-3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to skilled nursing facility requirements

The requirements, referred to in section 1395aa(d) of this title, with respect to a State are as follows:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) of this section and that meet the requirements established under subsection (f)(2) of this section, and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii) of this section.

The failure of the Secretary to establish requirements under subsection (f)(2) of this section shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of this section of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings, but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3) of this section; but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

(4) Skilled nursing facility administrator standards

By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) of this section respecting the qualification of administrators of skilled nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii) of this section. Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B) of this section, or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A) of this section.

(f) Responsibilities of Secretary relating to skilled nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A) of this section, the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training,⁵ (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata⁶ basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities (subject to clause (iii)), as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) of this section if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a skilled nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II) of this section;

(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) of this section or section 1396r(g)(2)(B)(i) of this title, unless the survey shows that the facility is in compliance with the require-

⁵ So in original. A closing parenthesis probably should appear before the comma.

⁶ So in original. Probably should be "pro rata".

ments of subsections (b), (c), and (d) of this section; or

(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) of this section or section 1396r(h)(2)(A)(ii) of this title of not less than \$5,000, or has been subject to a remedy described in clause (i) or (iii) of subsection (h)(2)(B) of this section, subsection (h)(4) of this section, section 1396r(h)(1)(B)(i) of this title, or in clause (i), (iii), or (iv) of section 1396r(h)(2)(A) of this title, or

(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the skilled nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of this subchapter) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3) of this section, by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) of this section must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from skilled nursing facilities.

(4) Secretarial standards for qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4) of this section, the Secretary shall develop, by not later than March 1, 1989, stand-

ards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) of this section with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3) of this section, and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) of this section for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii) of this section.

(7) List of items and services furnished in skilled nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this subchapter for extended care services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Special focus facility program**(A) In general**

The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement⁷ of this chapter.

(B) Periodic surveys

Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(g) Survey and certification process**(1) State and Federal responsibility****(A) In general**

Pursuant to an agreement under section 1395aa of this title, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a

resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry**(i) In general**

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys**(A) Standard survey****(i) In general**

Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed \$2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) of this section

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

and an audit of the residents' assessments under subsection (b)(3) of this section to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c) of this section.

(iii) Frequency

(I) In general

Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d) of this section. Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) of this section on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d) of this section, or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supercedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

(C) Remedies for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d) of this section, the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such requirements.

(4) Investigation of complaints and monitoring compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by skilled nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d) of this section, if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities.

(5) Disclosure of results of inspections and activities**(A) Public information**

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to

those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or subchapter XIX of this chapter,

(iii) copies of statements of ownership under section 1320a-3 of this title, and

(iv) information disclosed under section 1320a-5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]) of the State's findings of non-compliance with any of the requirements of subsections (b), (c), and (d) of this section, or of any adverse action taken against a skilled nursing facility under paragraph (1), (2), or (4) of subsection (h) of this section, with respect to a skilled nursing facility in the State.

(C) Notice to physicians and skilled nursing facility administrator licensing board

If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

(D) Access to fraud control units

Each State shall provide its State medicare fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(E) Submission of survey and certification information to the Secretary

In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) Enforcement process**(1) In general**

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) of this section or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d) of

this section, and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(i) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Secretarial authority

(A) In general

With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) of this section, and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this subchapter and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments under this subchapter with respect to all individuals entitled to benefits under this subchapter in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

(I) In general

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties

In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direc-

tion of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or un-

corrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(C) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d) of this section, if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

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

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

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(D) Assuring prompt compliance

If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d) of this section, within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

(E) Repeated noncompliance

In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2) of this section, has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (B)(i), and

(ii) monitor the facility under subsection (g)(4)(B) of this section,

until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d) of this section, and that it will remain in compliance with such requirements.

(3) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d) of this section.

(4) Immediate termination of participation for facility where Secretary finds noncompliance and immediate jeopardy

If the Secretary finds that a skilled nursing facility has not met a requirement of sub-

section (b), (c), or (d) of this section, and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary, subject to section 1320a-7j(h) of this title, shall terminate the facility's participation under this subchapter. If the facility's participation under this subchapter is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this subchapter consistent with the requirements of subsection (c)(2) and section 1320a-7j(h) of this title.

(5) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

(6) Sharing of information

Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XIX of this chapter, including investigations by State medicaid fraud control units.

(i) Nursing Home Compare website

(1) Inclusion of additional information

(A) In general

The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the "Nursing Home Compare" Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1320a-7j(g) of this title, including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting "nursing home staff hours per resident day");

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1320a-7j(f) of this title, including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside the facility;

(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

(III)⁸ the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

(B) Deadline for provision of information

(i) In general

Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after March 23, 2010.

(ii) Exception

The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1320a-7j(g) of this title are implemented.

(2) Review and modification of website

(A) In general

The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before March 23, 2010; and

⁸ So in original. Probably should be cl. (vi).

(ii) not later than 1 year after March 23, 2010, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation

In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

- (i) State long-term care ombudsman programs;
- (ii) consumer advocacy groups;
- (iii) provider stakeholder groups; and
- (iv) any other representatives of programs or groups the Secretary determines appropriate.

(3) Funding

The Secretary shall transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1395i of this title a one-time allocation of \$11,000,000. The amount shall be available on October 6, 2014. Such sums shall remain available until expended. Such sums shall be used to implement section 1320a-7j(g) of this title.

(j) Construction

Where requirements or obligations under this section are identical to those provided under section 1396r of this title, the fulfillment of those requirements or obligations under section 1396r of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(Aug. 14, 1935, ch. 531, title XVIII, § 1819, as added and amended Pub. L. 100-203, title IV, §§ 4201(a)(3), 4202(a)(2), 4203(a)(2), 4206, Dec. 22, 1987, 101 Stat. 1330-160, 1330-175, 1330-179, 1330-182; Pub. L. 100-360, title IV, § 411(l)(1)(A), (2)(A)-(D), (F)-(L)(i), (4), (5), (7), (11), July 1, 1988, 102 Stat. 800-805, as amended Pub. L. 100-485, title VI, § 608(d)(27)(A), (C), (D), (I), (L), Oct. 13, 1988, 102 Stat. 2422, 2423; Pub. L. 101-239, title VI, § 6901(b)(1), (3), (d)(4), Dec. 19, 1989, 103 Stat. 2298, 2301; Pub. L. 101-508, title IV, §§ 4008(h)(1)(B)-(F)(i), (G), (2)(B)-(N), (m)(3)(F)(E)], 4206(d)(1), Nov. 5, 1990, 104 Stat. 1388-46 to 1388-50, 1388-54, 1388-116; Pub. L. 102-375, title VII, § 708(a)(1)(A), Sept. 30, 1992, 106 Stat. 1291; Pub. L. 103-432, title I, §§ 106(c)(1)(A), (2)(A), (3)(A), (4)(A), (B), (d)(1)-(5), 110(b), Oct. 31, 1994, 108 Stat. 4406-4408; Pub. L. 105-15, § 1, May 15, 1997, 111 Stat. 34; Pub. L. 105-33, title IV, § 4432(b)(5)(A), 4755(a), Aug. 5, 1997, 111 Stat. 421, 526; Pub. L. 106-554, § 1(a)(6) [title IX, § 941(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-585; Pub. L. 108-173, title VII, § 736(a)(8), title IX, § 932(c)(2), Dec. 8, 2003, 117 Stat. 2355, 2401; Pub. L. 111-148, title VI, §§ 6101(c)(1)(A), 6103(a)(1), (2)(A), (3), (c)(1), 6111(a), 6113(b), 6121(a), Mar. 23, 2010, 124 Stat. 702, 704, 706, 709, 713, 719, 720; Pub. L. 113-185, § 2(c)(4)(B), Oct. 6, 2014, 128 Stat. 1966.)

AMENDMENT OF SUBSECTION (d)(1)

Pub. L. 111-148, title VI, § 6101(c)(1)(A), (2), Mar. 23, 2010, 124 Stat. 702, provided that, effective on the date on which the Secretary of Health and Human Services makes certain information available to the public, subsection (d)(1) of this section is amended by striking sub-

paragraph (B) and redesignating subparagraph (C) as subparagraph (B). See 2010 Amendment note and Effective Date of 2010 Amendment note below.

REFERENCES IN TEXT

The Older Americans Act of 1965, referred to in subsecs. (b)(4)(C)(ii)(IV), (c)(2)(B)(iii)(II), and (g)(5)(B), is Pub. L. 89-73, July 14, 1965, 79 Stat. 218. Section 307(a)(12) of the Act was repealed by Pub. L. 106-501, title III, § 306(5), Nov. 13, 2000, 114 Stat. 2244. Similar provisions are now contained in section 307(a)(9) of the Act, which is classified to section 3027(a)(9) of this title. Titles III and VII of the Act are classified generally to subchapters III (§3021 et seq.) and XI (§3058 et seq.) of chapter 35 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

Subparagraphs (B), (C), and (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101-239], referred to in subsec. (e)(2)(A), are set out below.

Section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, referred to in subsec. (f)(7)(A), probably means section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95-142, which is set out as a note under section 1395x of this title.

AMENDMENTS

2014—Subsec. (j)(3). Pub. L. 113-185 added par. (3).

2010—Subsec. (b)(5)(F). Pub. L. 111-148, § 6121(a)(2), inserted concluding provisions.

Subsec. (d)(1)(B). Pub. L. 111-148, § 6101(c)(1)(A), redesignated subpar. (C) as (B) and struck out former subpar. (B) which related to required notice to a State licensing agency of change in ownership, control interest, management, or certain positions of responsibility for a skilled nursing facility.

Subsec. (d)(1)(C). Pub. L. 111-148, § 6103(c)(1), added subpar. (C). Former subpar. (C) redesignated (B).

Subsec. (f)(2)(A)(i)(I). Pub. L. 111-148, § 6121(a)(1), inserted “(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training” after “curriculum”.

Subsec. (f)(8). Pub. L. 111-148, § 6103(a)(3), added par. (8).

Subsec. (g)(5)(E). Pub. L. 111-148, § 6103(a)(2)(A), added subpar. (E).

Subsec. (h)(2)(B)(ii). Pub. L. 111-148, § 6111(a)(1), designated existing provisions as subcl. (I), inserted heading, substituted “Subject to subclause (II), the Secretary” for “The Secretary”, and added subcls. (II) to (IV).

Subsec. (h)(4). Pub. L. 111-148, § 6113(b), substituted “the Secretary, subject to section 1320a-7(h) of this title, shall terminate” for “the Secretary shall terminate” and “subsection (c)(2) and section 1320a-7j(h) of this title” for “subsection (c)(2)”.

Subsec. (h)(5). Pub. L. 111-148, § 6111(a)(2), inserted “(i)(IV),” after “(i),”.

Subsecs. (i), (j). Pub. L. 111-148, § 6103(a)(1), added subsec. (i) and redesignated former subsec. (i) as (j).

2003—Subsec. (b)(4)(C)(i). Pub. L. 108-173, § 736(a)(8)(A), substituted “at least” for “at least at least”.

Subsec. (d)(1)(A). Pub. L. 108-173, § 736(a)(8)(B), substituted “physical, mental” for “physical mental”.

Subsec. (f)(2)(B)(iii). Pub. L. 108-173, § 932(c)(2)(A), substituted “subparagraphs (C) and (D)” for “subparagraph (C)” in introductory provisions.

Pub. L. 108-173, § 736(a)(8)(C), realigned margins of concluding provisions.

Subsec. (f)(2)(D). Pub. L. 108-173, § 932(c)(2)(B), added subpar. (D).

2000—Subsec. (b)(8). Pub. L. 106-554 added par. (8).

1997—Subsec. (b)(3)(C)(i). Pub. L. 105-33, § 4432(b)(5)(A), substituted “Subject to the timeframes prescribed by the Secretary under section 1395yy(e)(6) of this title, such” for “Such” in introductory provisions.

Subsec. (f)(2)(B)(iii). Pub. L. 105-15, §1(1), inserted "subject to subparagraph (C)," after "(iii)".

Subsec. (f)(2)(C). Pub. L. 105-15, §1(2), added subpar. (C).

Subsec. (g)(1)(D), (E). Pub. L. 105-33, §4755(a), added subpar. (D) and redesignated former subpar. (D) as (E). 1994—Subsec. (b)(3)(C)(i)(I). Pub. L. 103-432, §110(b), substituted "but no later than 14 days" for "but no later than not later than 14 days".

Subsec. (b)(5)(D). Pub. L. 103-432, §106(d)(1), struck out comma before "or a new competency evaluation program".

Subsec. (b)(5)(G). Pub. L. 103-432, §106(d)(2), substituted "licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician" for "or licensed or certified social worker".

Subsec. (c)(1)(D). Pub. L. 103-432, §106(c)(2)(A), inserted at end "In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this subchapter to have access to the services of such a consultant on a timely basis."

Subsec. (c)(6)(B)(i). Pub. L. 103-432, §106(c)(3)(A), substituted "\$100" for "\$50".

Subsec. (e)(2)(B). Pub. L. 103-432, §106(c)(4)(A), inserted ", but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection" after "individual disputing the findings" in first sentence.

Subsec. (f)(2)(B)(i). Pub. L. 103-432, §106(d)(3), substituted "facilities (subject to clause (iii))," for "facilities."

Subsec. (f)(2)(B)(iii)(I)(b). Pub. L. 103-432, §106(c)(1)(A), inserted before semicolon at end ", unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section".

Subsec. (f)(2)(B)(iii)(I)(c). Pub. L. 103-432, §106(d)(4), substituted "clause" for "clauses" in two places.

Subsec. (g)(1)(C). Pub. L. 103-432, §106(c)(4)(B), substituted second sentence for former second sentence which read as follows: "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations."

Subsec. (g)(5)(B). Pub. L. 103-432, §106(d)(5), substituted "paragraph" for "paragraphs" before "(1), (2), or (4) of subsection (h)".

1992—Subsecs. (c)(2)(B)(iii)(II), (g)(5)(B). Pub. L. 102-375 substituted "title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act" for "section 307(a)(12) of the Older Americans Act of 1965".

1990—Subsec. (b)(1)(B). Pub. L. 101-508, §4008(h)(2)(B), inserted at end "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph."

Subsec. (b)(3)(C)(i)(I). Pub. L. 101-508, §4008(h)(2)(C), substituted "not later than 14 days" for "4 days".

Subsec. (b)(4)(A)(vii). Pub. L. 101-508, §4008(h)(2)(D), added cl. (vii).

Subsec. (b)(4)(C)(ii)(IV), (V). Pub. L. 101-508, §4008(h)(2)(E), added subcls. (IV) and (V).

Subsec. (b)(5)(A). Pub. L. 101-508, §4008(h)(1)(B), designated existing provisions as cl. (i), in introductory provisions substituted "Except as provided in clause (ii), a skilled nursing facility" for "A skilled nursing facility" and "on a full-time basis" for "(on a full-time, temporary, per diem, or other basis)", redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Subsec. (b)(5)(C). Pub. L. 101-508, §4008(h)(1)(C), substituted "any State registry established under subsection (e)(2)(A) of this section that the facility believes will include information" for "the State registry established under subsection (e)(2)(A) of this section as to information in the registry".

Subsec. (b)(5)(D). Pub. L. 101-508, §4008(h)(1)(D), inserted before period at end ", or a new competency evaluation program" after "and competency evaluation program".

Subsec. (b)(5)(F)(i). Pub. L. 101-508, §4008(h)(2)(F), substituted "(G) or a registered dietician," for "(G)".

Subsec. (c)(1)(A). Pub. L. 101-508, §4008(h)(2)(G)(B)(ii), inserted at end "A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this subchapter or to medical assistance under subchapter XIX of this chapter."

Subsec. (c)(1)(A)(iv). Pub. L. 101-508, §4008(h)(2)(H), inserted before period at end "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request".

Subsec. (c)(1)(A)(x), (xi). Pub. L. 101-508, §4008(h)(2)(G)(i), added cl. (x) and redesignated former cl. (x) as (xi).

Subsec. (c)(1)(B)(ii). Pub. L. 101-508, §4008(h)(2)(I), inserted "including the notice (if any) of the State developed under section 1396r(e)(6) of this title" after "in such rights".

Subsec. (c)(1)(E). Pub. L. 101-508, §4206(d)(1), added subpar. (E).

Subsec. (e)(1)(A). Pub. L. 101-508, §4008(h)(2)(J), substituted "subsection (f)(2) of this section" for "clause (i) or (ii) of subsection (f)(2)(A) of this section".

Subsec. (e)(2)(A). Pub. L. 101-508, §4008(h)(2)(K)(i), inserted before period at end ", or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989".

Subsec. (e)(2)(C). Pub. L. 101-508, §4008(h)(2)(K)(ii), added subpar. (C).

Subsec. (f)(2)(A)(ii). Pub. L. 101-508, §4008(m)(3)(F)(E), struck out "and" after semicolon at end.

Subsec. (f)(2)(A)(iv). Pub. L. 101-508, §4008(h)(1)(E), struck out "and" at end of subcl. (I), inserted "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program" after "nurse aide" and substituted ", and" for period at end of subcl. (II), and added subcl. (III).

Subsec. (f)(2)(B). Pub. L. 101-508, §4008(h)(1)(G), inserted "(through subcontract or otherwise)" after "may not delegate" in second sentence.

Subsec. (f)(2)(B)(iii)(I). Pub. L. 101-508, §4008(h)(1)(F)(i), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: "offered by or in a skilled nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d) of this section, within the previous 2 years, or".

Subsec. (g)(1)(C). Pub. L. 101-508, §4008(h)(2)(L), inserted at end "A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual."

Subsec. (g)(5)(A)(i). Pub. L. 101-508, §4008(h)(2)(M), substituted "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans" for "deficiencies and plans".

Subsec. (g)(5)(B). Pub. L. 101-508, §4008(h)(2)(N), substituted "or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h) of this section, with respect" for "with respect".

1989—Subsec. (b)(5)(A). Pub. L. 101-239, §6901(b)(1)(A), substituted "October 1, 1990" for "January 1, 1990" in introductory provisions.

Subsec. (b)(5)(B). Pub. L. 101-239, §6901(b)(1)(B), substituted "January 1, 1990" and "October 1, 1990" for "July 1, 1989" and "January 1, 1990", respectively.

Subsec. (c)(1)(A)(ii)(II). Pub. L. 101-239, §6901(d)(4)(A), substituted "Secretary until such an order could reasonably be obtained" for "Secretary" until such an order could reasonably be obtained".

Subsec. (c)(1)(A)(v)(I). Pub. L. 101-239, § 6901(d)(4)(B), substituted "accommodation" for "accommodations".

Subsec. (f)(2)(A)(i)(D). Pub. L. 101-239, § 6901(d)(4)(C), substituted "and content of the curriculum" for "content of the curriculum".

Pub. L. 101-239, § 6901(b)(3)(A), inserted "care of cognitively impaired residents," after "social service needs."

Subsec. (f)(2)(A)(ii). Pub. L. 101-239, § 6901(b)(3)(B), substituted "recognition of mental health and social service needs, care of cognitively impaired residents" for "cognitive, behavioral and social care".

Subsec. (f)(2)(A)(iv). Pub. L. 101-239, § 6901(b)(3)(C), (D), added cl. (iv).

Subsec. (h)(2)(C). Pub. L. 101-239, § 6901(d)(4)(D), inserted "after the effective date of the findings" after "6 months" in introductory provisions.

1988—Subsec. (b)(3)(A)(iii). Pub. L. 100-360, § 411(l)(2)(B), struck out "in the case of a resident eligible for benefits under subchapter XIX of this chapter," before "uses an instrument".

Subsec. (b)(3)(A)(iv). Pub. L. 100-360, § 411(l)(2)(A), as amended by Pub. L. 100-485, § 608(d)(27)(C), struck out "in the case of a resident eligible for benefits under this part," before "includes the identification".

Subsec. (b)(3)(B)(ii)(III). Pub. L. 100-360, § 411(l)(2)(C), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a-7a of this title."

Subsec. (b)(3)(C)(i)(I). Pub. L. 100-360, § 411(l)(1)(A)(i), substituted "than January 1, 1991" for "than October 1, 1990".

Subsec. (b)(4)(C)(i). Pub. L. 100-360, § 411(l)(1)(A)(ii), substituted "24-hour licensed nursing" for "24-hour nursing", "must use" for "must employ", and "at least 8 consecutive hours a day," for "during the day tour of duty (of at least 8 hours a day)".

Subsec. (b)(5)(A). Pub. L. 100-360, § 411(l)(2)(D)(i), as amended by Pub. L. 100-485, § 608(d)(27)(D), struck out "who is not a licensed health professional (as defined in subparagraph (E))," after "any individual".

Pub. L. 100-360, § 411(l)(1)(A)(iii), substituted "January 1, 1990" for "October 1, 1989, (or January 1, 1990, in the case of an individual used by the facility as a nurse aide before July 1, 1989)".

Subsec. (b)(5)(A)(ii). Pub. L. 100-360, § 411(l)(2)(D)(ii), substituted "nursing or nursing-related services" for "such services".

Subsec. (b)(5)(G). Pub. L. 100-360, § 411(l)(2)(D)(iii), inserted "physical or occupational therapy assistant," after "occupational therapist".

Subsec. (c)(1)(D). Pub. L. 100-360, § 411(l)(1)(A)(iv), as added by Pub. L. 100-485, § 608(d)(27)(A), added subpar. (D).

Subsec. (c)(2)(A)(v). Pub. L. 100-360, § 411(l)(2)(F), substituted "for a stay at the facility" for "an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this subchapter and subchapter XIX of this chapter".

Subsec. (c)(6). Pub. L. 100-360, § 411(l)(2)(G), substituted "upon the written" for "once the facility accepts the written" in subpar. (A)(ii), and "Upon written" for "Upon a facility's acceptance of written" in subpar. (B).

Subsec. (e)(1)(A). Pub. L. 100-360, § 411(l)(1)(A)(v), formerly § 411(l)(1)(A)(iv), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "January" for "March".

Subsec. (e)(1)(B). Pub. L. 100-360, § 411(l)(1)(A)(vi), formerly § 411(l)(1)(A)(v), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "January" for "March".

Subsec. (e)(2)(A). Pub. L. 100-360, § 411(l)(1)(A)(vii), formerly § 411(l)(1)(A)(vi), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "January" for "March".

Subsec. (e)(2)(B). Pub. L. 100-360, § 411(l)(2)(H), inserted after first sentence "The State shall make available to the public information in the registry."

Subsec. (e)(3). Pub. L. 100-360, § 411(l)(2)(I), inserted "and discharges" after "transfers" in heading and in two places in text.

Pub. L. 100-360, § 411(l)(1)(A)(viii), formerly § 411(l)(1)(A)(vii), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "1989" for "1990".

Subsec. (e)(5). Pub. L. 100-360, § 411(l)(1)(A)(ix), formerly § 411(l)(1)(A)(viii), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "1990" for "1989" in introductory provisions.

Subsec. (f)(2)(A)(i)(I). Pub. L. 100-360, § 411(l)(2)(J), substituted "recognition of mental health and social service needs" for "cognitive, behavioral and social care".

Subsec. (f)(3). Pub. L. 100-360, § 411(l)(2)(I), inserted "and discharges" after "transfers" in heading and in text.

Pub. L. 100-360, § 411(l)(1)(A)(x), formerly § 411(l)(1)(A)(ix), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "1988" for "1989".

Subsec. (f)(6)(A). Pub. L. 100-360, § 411(l)(1)(A)(xi), formerly § 411(l)(1)(A)(x), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "January" for "July".

Subsec. (f)(6)(B). Pub. L. 100-360, § 411(l)(1)(A)(xii), formerly § 411(l)(1)(A)(xi), as redesignated by Pub. L. 100-485, § 608(d)(27)(A), substituted "April" for "October".

Subsec. (f)(7)(A). Pub. L. 100-360, § 411(l)(2)(K), substituted "residents" for "patients".

Subsec. (f)(7)(B). Pub. L. 100-360, § 411(l)(2)(L)(i), substituted "shall include" for "shall not include".

Subsec. (g)(1)(C). Pub. L. 100-360, § 411(l)(5)(A)-(C), substituted "and timely review" for "review", inserted "or by another individual used by the facility in providing services to such a resident" after "a nursing facility", and substituted "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority." for "If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding."

Subsec. (g)(1)(D). Pub. L. 100-360, § 411(l)(5)(D), substituted "to issue regulations to carry out this subsection" for "to establish standards under subsection (f) of this section".

Subsec. (g)(2)(A)(i). Pub. L. 100-360, § 411(l)(5)(E), amended third sentence generally. Prior to amendment, third sentence read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a-7a of this title."

Subsec. (g)(2)(B)(ii). Pub. L. 100-360, § 411(l)(5)(F), as added by Pub. L. 100-485, § 608(d)(27)(I), substituted "practicable" for "practical".

Subsec. (g)(2)(C)(i). Pub. L. 100-360, § 411(l)(4), substituted "January" for "October".

Subsec. (g)(3)(D). Pub. L. 100-360, § 411(l)(5)(G), formerly § 411(l)(5)(F), as redesignated by Pub. L. 100-485, § 608(d)(27)(I), substituted "on the basis of that survey" for "on that basis".

Subsec. (g)(4). Pub. L. 100-360, § 411(l)(5)(H), formerly § 411(l)(5)(G), as redesignated by Pub. L. 100-485,

§ 608(d)(27)(I), struck out “chronically” after “enforcement actions against” in last sentence.

Subsec. (h)(2)(B)(ii). Pub. L. 100-360, § 411(l)(7)(A), substituted “. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.” for “and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1320a-7a of this title.”

Subsec. (h)(5). Pub. L. 100-360, § 411(l)(11), as added by Pub. L. 100-485, § 608(d)(27)(L), substituted “clauses (i), and (iii) of paragraph (2)(B)” for “clauses (i), (iii), and (iv) of paragraph (2)(A)”.

Subsec. (h)(6). Pub. L. 100-360, § 411(l)(7)(B), inserted “by such facilities” after “be made available”.

1987—Subsecs. (g) to (i). Pub. L. 100-203, §§ 4202(a)(2), 4203(a)(2), 4206, added subsecs. (g), (h), and (i), respectively.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title VI, § 6101(c)(2), Mar. 23, 2010, 124 Stat. 702, provided that: “The amendments made by paragraph (1) [amending this section and section 1396r of this title] shall take effect on the date on which the Secretary [of Health and Human Services] makes the information described in subsection (b)(1) [probably means subsec. (b) of section 6101, which is set out as a note under section 1320a-3 of this title] available to the public under such subsection.”

Pub. L. 111-148, title VI, § 6103(a)(2)(B), Mar. 23, 2010, 124 Stat. 706, provided that: “The amendment made by this paragraph [amending this section] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].”

Pub. L. 111-148, title VI, § 6103(c)(3), Mar. 23, 2010, 124 Stat. 710, provided that: “The amendments made by this subsection [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].”

Pub. L. 111-148, title VI, § 6111(c), Mar. 23, 2010, 124 Stat. 716, provided that: “The amendments made by this section [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].”

Amendment by section 6113(b) of Pub. L. 111-148 effective 1 year after Mar. 23, 2010, see section 6113(c) of Pub. L. 111-148, set out as a note under section 1320a-7j of this title.

Pub. L. 111-148, title VI, § 6121(c), Mar. 23, 2010, 124 Stat. 721, provided that: “The amendments made by this section [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].”

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title IX, § 932(d), Dec. 8, 2003, 117 Stat. 2402, provided that: “The amendments made by this section [amending this section and sections 1395cc, 1395ff, and 1396r of this title] shall apply to appeals filed on or after October 1, 2004.”

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, § 1(a)(6) [title IX, § 941(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-586, provided that: “The amendments made by this section [amending this section and section 1396r of this title] shall take effect on January 1, 2003.”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-33, title IV, § 4432(d), Aug. 5, 1997, 111 Stat. 422, provided that: “The amendments made by this section [amending this section and sections 1395k, 1395l, 1395u, 1395x, 1395y, 1395cc, 1395tt, and 1395yy of this title] are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) [amending this section and sec-

tions 1395k, 1395l, 1395u, 1395x, 1395y, 1395cc, 1395tt, and 1395yy of this title] shall apply to items and services furnished on or after July 1, 1998.”

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103-432, title I, § 106(c)(1)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: “The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of OBRA-1990 [Pub. L. 101-508].”

Pub. L. 103-432, title I, § 106(c)(2)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: “The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of OBRA-1987 [Pub. L. 100-203].”

Pub. L. 103-432, title I, § 106(c)(3)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: “The amendment made by subparagraph (A) [amending this section] shall take effect January 1, 1995.”

Pub. L. 103-432, title I, § 106(c)(4)(C), Oct. 31, 1994, 108 Stat. 4407, provided that: “The amendments made by this paragraph [amending this section] shall take effect January 1, 1995.”

Pub. L. 103-432, title I, § 106(d)(7), Oct. 31, 1994, 108 Stat. 4407, provided that: “The amendments made by this subsection [amending this section and provisions set out as a note below] shall take effect as if included in the enactment of OBRA-1990 [Pub. L. 101-508].”

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102-375 inapplicable with respect to fiscal year 1993, see section 4(b) of Pub. L. 103-171, set out as a note under section 3001 of this title.

Amendment by Pub. L. 102-375 inapplicable with respect to fiscal year 1992, see section 905(b)(6) of Pub. L. 102-375, set out as a note under section 3001 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101-508, title IV, § 4008(h)(1)(F)(ii), Nov. 5, 1990, 104 Stat. 1388-47, as amended by Pub. L. 103-432, title I, § 106(d)(6), Oct. 31, 1994, 108 Stat. 4407, provided that:

“(I) The amendments made by clause (i) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203], except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

“(aa) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.];

“(bb) was subject to a denial of payment under either such title;

“(cc) was assessed a civil money penalty not less than \$5,000 for deficiencies in skilled nursing facility standards;

“(dd) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

“(ee) pursuant to State action, was closed or had its residents transferred.

“(II) Notwithstanding subclause (I) and subject to section 1819(f)(2)(B)(iii)(I) of the Social Security Act [42 U.S.C. 1395i-3(f)(2)(B)(iii)(I)] (as amended by clause (i)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility described in subclause (I) if, during the previous 2 years, item (aa), (bb), (cc), (dd), or (ee) of subclause (I) did not apply to the facility.”

Pub. L. 101-508, title IV, § 4008(h)(1)(H), Nov. 5, 1990, 104 Stat. 1388-48, provided that: “Except as provided in subparagraph (F) [amending this section and enacting provisions set out as a note above], the amendments made by this subsection [probably means this para-

graph, amending this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203].”

Pub. L. 101-508, title IV, § 4008(h)(2)(P), Nov. 5, 1990, 104 Stat. 1388-50, provided that: “The amendments made by this paragraph [amending this section and sections 1395x and 1395yy of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203].”

Pub. L. 101-508, title IV, § 4206(e)(1), Nov. 5, 1990, 104 Stat. 1388-117, provided that: “The amendments made by subsections (a) and (d) [amending this section and sections 1395cc and 1395bbb of this title] shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990].”

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-239, title VI, § 6901(b)(6), Dec. 19, 1989, 103 Stat. 2300, provided that:

“(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and sections 1396b and 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203].

“(B) EXCEPTION.—The amendments made by paragraph (3) [amending this section and section 1396r of this title] shall apply to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on the date of the enactment of this Act [Dec. 19, 1989], but shall not affect competency evaluations conducted under programs offered before the end of such period.”

Pub. L. 101-239, title VI, § 6901(d)(6), Dec. 19, 1989, 103 Stat. 2301, provided that:

“(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and sections 1396i and 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203].

“(B) EXCEPTION.—The amendment made by paragraph (1) [amending section 1396r of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].”

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100-485 effective as if originally included in the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 100-203, title IV, § 4204, Dec. 22, 1987, 101 Stat. 1330-182, as amended by Pub. L. 100-360, title IV, § 411(l)(9), July 1, 1988, 102 Stat. 805; Pub. L. 100-485, title VI, § 608(d)(27)(K), Oct. 13, 1988, 102 Stat. 2423, provided that:

“(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1819 of the Social Security Act [42 U.S.C. 1395i-3], the amendments made by sections 4201 and 4202 [enacting and amending this section and amending sections 1395x, 1395aa, 1395tt, and 1395yy of this title] (relating to skilled nursing facility requirements and survey and certification requirements) shall apply to services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date.

“(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act [42 U.S.C. 1395i-3], the amendments made by section 4203 of this Act [amending this section and section 1395aa of this title] apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date.

“(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act [42 U.S.C. 1395x(j)].

“(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this part [part 1 of subtitle C (§§ 4201-4206), enacting this section, amending this section and sections 1395x, 1395aa, 1395tt, and 1395yy of this title, and enacting provisions set out as notes under this section] and implementing the amendments made by this part.”

GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS

Pub. L. 111-148, title VI, § 6103(d)(1), (3), Mar. 23, 2010, 124 Stat. 710, provided that:

“(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle [subtitle B (§§ 6101-6121) of title VI of Pub. L. 111-148, enacting section 1320a-7j of this title, amending this section and sections 1320a-3, 1320a-7j, 1395yy, 1396a, and 1396r of this title, and enacting provisions set out as notes under this section and sections 1320a-3, 1320a-7j, and 1396r of this title] referred to as the ‘Secretary’) shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility’s plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

“(3) DEFINITIONS.—In this subsection:

“(A) NURSING FACILITY.—The term ‘nursing facility’ has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

“(B) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.

“(C) SKILLED NURSING FACILITY.—The term ‘skilled nursing facility’ has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)).”

DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE

Pub. L. 111-148, title VI, § 6103(e), Mar. 23, 2010, 124 Stat. 710, provided that: “Not later than 1 year after the date of enactment of this Act [Mar. 23, 2010], the Secretary [of Health and Human Services] shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

“(1) The documentation on nursing facilities that is available to the public.

“(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

“(3) General information on consumer rights with respect to nursing facilities.

“(4) The nursing facility survey process (on a national and State-specific basis).

“(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.”

NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES

Pub. L. 111-148, title VI, §6114, Mar. 23, 2010, 124 Stat. 720, provided that:

“(a) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

“(b) CONDUCT OF DEMONSTRATION PROJECTS.—

“(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

“(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

“(c) DURATION AND IMPLEMENTATION.—

“(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

“(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act [Mar. 23, 2010].

“(d) DEFINITIONS.—In this section:

“(1) NURSING FACILITY.—The term ‘nursing facility’ has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

“(2) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.

“(3) SKILLED NURSING FACILITY.—The term ‘skilled nursing facility’ has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a) [1395i-3(a)]).

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

“(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.”

REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES

Pub. L. 108-173, title I, §107(b), Dec. 8, 2003, 117 Stat. 2169, provided that:

“(1) REVIEW.—

“(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

“(B) SPECIFIC MATTERS REVIEWED.—In conducting the review under subparagraph (A), the Secretary shall—

“(i) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

“(ii) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

“(2) REPORT.—

“(A) IN GENERAL.—Not later than the date that is 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall submit a report to Congress on the study conducted under paragraph (1)(A).

“(B) CONTENTS.—The report submitted under subparagraph (A) shall contain—

“(i) a description of the plans of the Secretary to implement the provisions of this Act [see Tables for classification] in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

“(ii) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.”

STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §107], Nov. 29, 1999, 113 Stat. 1536, 1501A-328, provided that:

“(a) STUDY.—The Secretary of Health and Human Services shall conduct a study that—

“(1) identifies variations in State licensure and certification standards for health care providers (including nursing and allied health professionals) and other individuals providing respiratory therapy in skilled nursing facilities;

“(2) examines State requirements relating to respiratory therapy competency examinations for such providers and individuals; and

“(3) determines whether regular respiratory therapy competency examinations or certifications should be required under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for such providers and individuals.

“(b) REPORT.—Not later than 18 months after the date of enactment of this Act [Nov. 29, 1999], the Secretary of Health and Human Services shall submit to Congress a report on the results of the study conducted under this section, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.”

RETROACTIVE REVIEW

Pub. L. 105-33, title IV, §4755(c), Aug. 5, 1997, 111 Stat. 527, provided that: “The procedures developed by a State under the amendments made by subsection[s] (a) and (b) [amending this section and section 1396r of this title] shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.”

STUDY AND REPORT ON DEEMING FOR NURSING FACILITIES AND RENAL DIALYSIS FACILITIES

Pub. L. 104-134, title I, §101(d) [title V, §516(d)], Apr. 26, 1996, 110 Stat. 1321-211, 1321-248; renumbered title I, Pub. L. 104-140, §1(a), May 2, 1996, 110 Stat. 1327, provided that:

“(1) STUDY.—The Secretary of Health and Human Services shall provide for—

“(A) a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying skilled nursing facilities for compliance with the conditions and requirements of sections 1819 and 1861(j) of the Social Security Act [42 U.S.C. 1395i-3, 1395x(j)] and nursing facilities for compliance with the conditions of section 1919 of such Act [42 U.S.C. 1396r], and

“(B) a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying renal dialysis facilities for compliance with the conditions and requirements of section 1881(b) of the Social Security Act [42 U.S.C. 1395rr(b)].

“(2) REPORT.—Not later than July 1, 1997, the Secretary shall transmit to Congress a report on each of the studies provided for under paragraph (1). The report on the study under paragraph (1)(A) shall include (and the report on the study under paragraph (1)(B) may include) a specific framework, where appropriate, for implementing a process under which facilities covered under the respective study may be deemed to meet applicable medicare conditions and requirements if they are accredited by a national accreditation body.”

MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES

Pub. L. 101-508, title IV, § 4008(h)(2)(O), Nov. 5, 1990, 104 Stat. 1388-50, provided that: “Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 [Dec. 22, 1987] with respect to services described in clauses (ii), (iv), and (v) of section 1819(b)(4)(A) of the Social Security Act [42 U.S.C. 1395i-3(b)(4)(A)(ii), (iv), and (v)] shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.”

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS; PUBLICATION OF PROPOSED REGULATIONS

Pub. L. 101-239, title VI, § 6901(b)(2), Dec. 19, 1989, 103 Stat. 2298, provided that: “The Secretary of Health and Human Services shall issue proposed regulations to establish the requirements described in sections 1819(f)(2) and 1919(f)(2) of the Social Security Act [42 U.S.C. 1395i-3(f)(2), 1396r(f)(2)] by not later than 90 days after the date of the enactment of this Act [Dec. 19, 1989].”

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; SATISFACTION OF REQUIREMENTS; WAIVER

Pub. L. 101-239, title VI, § 6901(b)(4)(B)-(D), Dec. 19, 1989, 103 Stat. 2299, provided that:

“(B) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act [42 U.S.C. 1395i-3(b)(5)(A), 1396r(b)(5)(A)] (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act [42 U.S.C. 1395i-3(e)(1)(A), 1396r(e)(1)(A)]), if such aide would have satisfied such requirement as of July 1, 1989, if a number of hours (not less than 60 hours) were substituted for ‘75 hours’ in sections 1819(f)(2) and 1919(f)(2) of such Act [42 U.S.C. 1395i-3(f)(2), 1396r(f)(2)], respectively, and if such aide had received, before July 1, 1989, at least the difference in the number of such hours in supervised practical nurse aide training or in regular in-service nurse aide education.

“(C) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide was found competent (whether or not by the State), before July 1, 1989, after the completion of a course of nurse aide training of at least 100 hours duration.

“(D) With respect to the nurse aide competency evaluation requirements described in sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act, a State may waive such requirements with respect to an individual who can demonstrate to the satisfaction of the State that such individual has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of the enactment of this Act [Dec. 19, 1989].”

EVALUATION AND REPORT ON IMPLEMENTATION OF RESIDENT ASSESSMENT PROCESS

Pub. L. 100-203, title IV, § 4201(c), Dec. 22, 1987, 101 Stat. 1330-174, provided that: “The Secretary of Health and Human Services shall evaluate, and report to Congress by not later than January 1, 1992, on the implementation of the resident assessment process for residents of skilled nursing facilities under the amendments made by this section [enacting this section and amending sections 1395x, 1395aa, 1395tt, and 1395yy of this title].”

ANNUAL REPORT ON STATUTORY COMPLIANCE AND ENFORCEMENT ACTIONS

Pub. L. 100-203, title IV, § 4205, Dec. 22, 1987, 101 Stat. 1330-182, provided that: “The Secretary of Health and Human Services shall report to the Congress annually on the extent to which skilled nursing facilities are complying with the requirements of subsections (b), (c), and (d) of section 1819 of the Social Security Act [42 U.S.C. 1395i-3(b), (c), (d)] (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1819(h) of such Act (as added by section 4203 of this Act).”

§ 1395i-3a. Protecting residents of long-term care facilities

(1) National Training Institute for surveyors

(A) In general

The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.].

(B) Activities carried out by the Institute

The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24

hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i-3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) Authorization

There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, \$12,000,000.

(2) Grants to State survey agencies

(A) In general

The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i-3; 1395r [1396r]).

(B) Use of funds

A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) Authorization

There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, \$5,000,000.

(Pub. L. 111-148, title VI, § 6703(b)(1), (2), Mar. 23, 2010, 124 Stat. 798, 799.)

REFERENCES IN TEXT

The Social Security Act, referred to in par. (1)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to this subchapter (§1395 et seq.) and subchapter XIX (§1396 et seq.), respectively, of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Elder Justice Act of 2009 and also as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

DEFINITIONS

Pub. L. 111-148, title VI, § 6702, Mar. 23, 2010, 124 Stat. 782, provided that: “Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act [42 U.S.C. 1397j] (as added by section 6703(a)) and is used in this subtitle [subtitle H (§§ 6701-6703) of title VI of Pub. L. 111-148, enacting this section and sections 1320b-25, 1397j, 1397j-1, 1397k to 1397k-3, 1397l, and 1397m to 1397m-5 of this title, amending sections 602, 604, 622, 671 to 673, 1320a-7, 1320a-7a, 1397, 1397a, 1397c to 1397e, and 1397g of this title, and enacting provisions set out as notes under sections 602 and 1305 of this title] has the meaning given such term by such section.”

§ 1395i-4. Medicare rural hospital flexibility program

(a) Establishment

Any State that submits an application in accordance with subsection (b) of this section may establish a medicare rural hospital flexibility program described in subsection (c) of this section.

(b) Application

A State may establish a medicare rural hospital flexibility program described in subsection (c) of this section if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

(1) assurances that the State—

(A) has developed, or is in the process of developing, a State rural health care plan that—

(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d) of this section) in the State;

(ii) promotes regionalization of rural health services in the State; and

(iii) improves access to hospital and other health services for rural residents of the State; and

(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the proc-

ess of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

(3) such other information and assurances as the Secretary may require.

(c) Medicare rural hospital flexibility program described

(1) In general

A State that has submitted an application in accordance with subsection (b) of this section, may establish a medicare rural hospital flexibility program that provides that—

(A) the State shall develop at least 1 rural health network (as defined in subsection (d) of this section) in the State; and

(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

(2) State designation of facilities

(A) In general

A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraphs (B), (C), and (D).

(B) Criteria for designation as critical access hospital

A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title, and that—

(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

(II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

(iv) meets such staffing requirements as would apply under section 1395x(e) of this title to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but

need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1395x(w)(1) of this title; and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1395x(aa)(2)(I) of this title.

(C) Recently closed facilities

A State may designate a facility as a critical access hospital if the facility—

(i) was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(D) Downsized facilities

A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

(i) is licensed by the State as a health clinic or a health center;

(ii) was a hospital that was downsized to a health clinic or health center; and

(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(E) Authority to establish psychiatric and rehabilitation distinct part units

(i) In general

Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1395ww(d)(1)(B) of this title, including any regulations adopted by the Secretary under such section.

(ii) Limitation on number of beds

The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

(iii) Exclusion of beds from bed count

In determining the number of beds of a critical access hospital for purposes of ap-

plying the bed limitations referred to in subparagraph (B)(iii) and subsection (f) of this section, the Secretary shall not take into account any bed established under clause (i).

(iv) Effect of failure to meet requirements

If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this subchapter to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.

(d) “Rural health network” defined

(1) In general

In this section, the term “rural health network” means, with respect to a State, an organization consisting of—

(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

(B) at least 1 hospital that furnishes acute care services.

(2) Agreements

(A) In general

Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

(B) Items described

The items described in this subparagraph are the following:

(i) Patient referral and transfer.

(ii) The development and use of communications systems including (where feasible)—

(I) telemetry systems; and

(II) systems for electronic sharing of patient data.

(iii) The provision of emergency and non-emergency transportation among the facility and the hospital.

(C) Credentialing and quality assurance

Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(i) 1 hospital that is a member of the network;

(ii) 1 peer review organization or equivalent entity; or

(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

(e) Certification by Secretary

The Secretary shall certify a facility as a critical access hospital if the facility—

(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c) of this section;

(2) is designated as a critical access hospital by the State in which it is located; and

(3) meets such other criteria as the Secretary may require.

(f) Permitting maintenance of swing beds

Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1395tt of this title under which the facility’s inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted.

(g) Grants

(1) Medicare rural hospital flexibility program

The Secretary may award grants to States that have submitted applications in accordance with subsection (b) of this section for—

(A) engaging in activities relating to planning and implementing a rural health care plan;

(B) engaging in activities relating to planning and implementing rural health networks;

(C) designating facilities as critical access hospitals; and

(D) providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking.

(2) Rural emergency medical services

(A) In general

The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

(B) Application

An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) of this section and paragraph (3) of that subsection.

(3) Upgrading data systems

(A) Grants to hospitals

The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments

made by the Balanced Budget Act of 1997 and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc-4 of this title, and other delivery system reform programs determined appropriate by the Secretary.

(B) Eligible small rural hospital defined

For purposes of this paragraph, the term “eligible small rural hospital” means a non-Federal, short-term general acute care hospital that—

- (i) is located in a rural area (as defined for purposes of section 1395ww(d) of this title); and
- (ii) has less than 50 beds.

(C) Application

A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(D) Amount of grant

A grant to a hospital under this paragraph may not exceed \$50,000.

(E) Use of funds

A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff on computer information systems, to offset costs related to the implementation of prospective payment systems and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc-4 of this title, and other delivery system reform programs determined appropriate by the Secretary.

(F) Reports

(i) Information

A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

(ii) Timing of submission

(I) Interim reports

The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects

involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(II) Final report

The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

(4) Additional requirements with respect to FLEX grants

With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

(A) Consultation with the state hospital association and rural hospitals on the most appropriate ways to use grants

A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

(B) Limitation on use of grant funds for administrative expenses

A State may not expend more than the lesser of—

- (i) 15 percent of the amount of the grant for administrative expenses; or
- (ii) the State’s federally negotiated indirect rate for administering the grant.

(5) Use of funds for Federal administrative expenses

Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (for each of fiscal years 2005 through 2008) and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.

(6) Providing mental health services and other health services to veterans and other residents of rural areas

(A) Grants to States

The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas (as defined for purposes of section 1395ww(d) of this title and including areas that are rural census tracts, as defined by the Administrator of the Health Resources and Services Administration), including for the provision of crisis intervention services and the detection of post-traumatic stress disorder, traumatic brain injury, and other signature injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom, and for referral of such veterans to medical facilities operated by the Department of Veterans Affairs, and for the delivery of such services to other residents of such rural areas.

(B) Application**(i) In general**

An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii) and (A)(iii) of subsection (b)(1).

(ii) Consideration of regional approaches, networks, or technology

The Secretary may, as appropriate in awarding grants to States under subparagraph (A), consider whether the application submitted by a State under this subparagraph includes 1 or more proposals that utilize regional approaches, networks, health information technology, telehealth, or telemedicine to deliver services described in subparagraph (A) to individuals described in that subparagraph. For purposes of this clause, a network may, as the Secretary determines appropriate, include Federally qualified health centers (as defined in section 1395x(aa)(4) of this title), rural health clinics (as defined in section 1395x(aa)(2) of this title), home health agencies (as defined in section 1395x(o) of this title), community mental health centers (as defined in section 1395x(ff)(3)(B) of this title) and other providers of mental health services, pharmacists, local government, and other providers deemed necessary to meet the needs of veterans.

(iii) Coordination at local level

The Secretary shall require, as appropriate, a State to demonstrate consultation with the hospital association of such State, rural hospitals located in such State, providers of mental health services, or other appropriate stakeholders for the provision of services under a grant awarded under this paragraph.

(iv) Special consideration of certain applications

In awarding grants to States under subparagraph (A), the Secretary shall give special consideration to applications submitted by States in which veterans make up a high percentage (as determined by the Secretary) of the total population of the State. Such consideration shall be given without regard to the number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in the areas in which mental health services and other health care services would be delivered under the application.

(C) Coordination with VA

The Secretary shall, as appropriate, consult with the Director of the Office of Rural Health of the Department of Veterans Affairs in awarding and administering grants to States under subparagraph (A).

(D) Use of funds

A State awarded a grant under this paragraph may, as appropriate, use the funds to

reimburse providers of services described in subparagraph (A) to individuals described in that subparagraph.

(E) Limitation on use of grant funds for administrative expenses

A State awarded a grant under this paragraph may not expend more than 15 percent of the amount of the grant for administrative expenses.

(F) Independent evaluation and final report

The Secretary shall provide for an independent evaluation of the grants awarded under subparagraph (A). Not later than 1 year after the date on which the last grant is awarded to a State under such subparagraph, the Secretary shall submit a report to Congress on such evaluation. Such report shall include an assessment of the impact of such grants on increasing the delivery of mental health services and other health services to veterans of the United States Armed Forces living in rural areas (as so defined and including such areas that are rural census tracts), with particular emphasis on the impact of such grants on the delivery of such services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom, and to other individuals living in such rural areas.

(7) Critical access hospitals transitioning to skilled nursing facilities and assisted living facilities**(A) Grants**

The Secretary may award grants to eligible critical access hospitals that have submitted applications in accordance with subparagraph (B) for assisting such hospitals in the transition to skilled nursing facilities and assisted living facilities.

(B) Application

An applicable critical access hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(C) Additional requirements

The Secretary may not award a grant under this paragraph to an eligible critical access hospital unless—

(i) local organizations or the State in which the hospital is located provides matching funds; and

(ii) the hospital provides assurances that it will surrender critical access hospital status under this subchapter within 180 days of receiving the grant.

(D) Amount of grant

A grant to an eligible critical access hospital under this paragraph may not exceed \$1,000,000.

(E) Funding

There are appropriated from the Federal Hospital Insurance Trust Fund under section 1395i of this title for making grants under this paragraph, \$5,000,000 for fiscal year 2008.

(F) Eligible critical access hospital defined

For purposes of this paragraph, the term “eligible critical access hospital” means a

critical access hospital that has an average daily acute census of less than 0.5 and an average daily swing bed census of greater than 10.0.

(h) Grandfathering provisions

(1) In general

Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to August 5, 1997, shall be deemed to have been certified by the Secretary under subsection (e) of this section as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c) of this section.

(2) Continuation of medical assistance facility and rural primary care hospital terms

Notwithstanding any other provision of this subchapter, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this subchapter to a “critical access hospital” shall be deemed to be a reference to a “medical assistance facility” or “rural primary care hospital”.

(3) State authority to waive 35-mile rule

In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II) of this section, as in effect before such date, the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(i) Waiver of conflicting part A provisions

The Secretary is authorized to waive such provisions of this part and part E of this subchapter as are necessary to conduct the program established under this section.

(j) Authorization of appropriations

There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g) of this section, \$25,000,000 in each of the fiscal years 1998 through 2002, for making grants to all States under paragraphs (1) and (2) of subsection (g) of this section, \$35,000,000 in each of fiscal years 2005 through 2008, for making grants to all States under paragraphs (1) and (2) of subsection (g), \$55,000,000 in each of fiscal years 2009 and 2010, for making grants to all States under paragraph (6) of subsection (g), \$50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1820, as added Pub. L. 101-239, title VI, § 6003(g)(1)(A), Dec. 19, 1989, 103 Stat. 2145; amended Pub. L. 101-508, title IV, § 4008(d)(1)–(3), (m)(2)(B), Nov. 5, 1990, 104 Stat. 1388-44, 1388-45, 1388-53; Pub. L. 103-432,

title I, § 102(a)(1), (2), (b)(1)(A), (2), (c), (f), (h), Oct. 31, 1994, 108 Stat. 4401-4404; Pub. L. 105-33, title IV, §§ 4002(f)(1), 4201(a), Aug. 5, 1997, 111 Stat. 329, 369; Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 321(a), title IV, §§ 401(b)(2), 403(a)(1), (b), (c), 409], Nov. 29, 1999, 113 Stat. 1536, 1501A-365, 1501A-369, 1501A-370, 1501A-375; Pub. L. 108-173, title I, § 101(e)(1), title IV, § 405(e)(1), (2), (f), (g)(1), (h), Dec. 8, 2003, 117 Stat. 2150, 2267-2269; Pub. L. 110-275, title I, § 121, July 15, 2008, 122 Stat. 2511; Pub. L. 111-148, title III, § 3129(a), (b), Mar. 23, 2010, 124 Stat. 426.)

REFERENCES IN TEXT

The Balanced Budget Act of 1997, referred to in subsec. (g)(3)(A), is Pub. L. 105-33, Aug. 5, 1997, 111 Stat. 251. For complete classification of this Act to the Code, see Tables.

The Patient Protection and Affordable Care Act, referred to in subsec. (g)(3)(A), (E), is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (h)(3), is section 405(h)(1) of Pub. L. 108-173, which amended this section. See 2003 Amendment note below.

AMENDMENTS

2010—Subsec. (g)(3)(A). Pub. L. 111-148, § 3129(b)(1), inserted “and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc-4 of this title, and other delivery system reform programs determined appropriate by the Secretary” before period at end.

Subsec. (g)(3)(E). Pub. L. 111-148, § 3129(b)(2), substituted “, to offset” for “,” and to offset” and inserted “and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc-4 of this title, and other delivery system reform programs determined appropriate by the Secretary” before period at end.

Subsec. (j). Pub. L. 111-148, § 3129(a), substituted “2010, for” for “2010, and for” and inserted “and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended” before period at end.

2008—Subsec. (g)(1)(D). Pub. L. 110-275, § 121(d), added subpar. (D).

Subsec. (g)(5). Pub. L. 110-275, § 121(b)(2), which directed insertion of “and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009)” after “2005”, was executed by making the insertion after “2008” to reflect the probable intent of Congress and the amendment by section 121(b)(1) of Pub. L. 110-275. See note below.

Pub. L. 110-275, § 121(b)(1), substituted “for each of fiscal years 2005 through 2008” for “beginning with fiscal year 2005”.

Subsec. (g)(6). Pub. L. 110-275, § 121(a), added par. (6).

Subsec. (g)(7). Pub. L. 110-275, § 121(e), added par. (7).

Subsec. (j). Pub. L. 110-275, § 121(c), substituted “2002, for” for “2002, and for” and inserted “, for making grants to all States under paragraphs (1) and (2) of subsection (g), \$55,000,000 in each of fiscal years 2009 and 2010, and for making grants to all States under paragraph (6) of subsection (g), \$50,000,000 in each of fiscal

years 2009 and 2010, to remain available until expended” before period at end.

2003—Subsec. (c)(2)(B)(i)(II). Pub. L. 108-173, § 405(h)(1), inserted “before January 1, 2006,” after “is certified”.

Subsec. (c)(2)(B)(iii). Pub. L. 108-173, § 405(e)(1), substituted “25” for “15 (or, in the case of a facility under an agreement described in subsection (f) of this section, 25)”.

Subsec. (c)(2)(E). Pub. L. 108-173, § 405(g)(1), added subpar. (E).

Subsec. (f). Pub. L. 108-173, § 405(e)(2), struck out “and the number of beds used at any time for acute care inpatient services does not exceed 15 beds” after “does not exceed 25 beds”.

Subsec. (g)(4), (5). Pub. L. 108-173, § 405(f)(2), added pars. (4) and (5).

Subsec. (h). Pub. L. 108-173, § 405(h)(2)(A), substituted “provisions” for “of certain facilities” in heading.

Subsec. (h)(3). Pub. L. 108-173, § 405(h)(2)(B), added par. (3).

Subsec. (i). Pub. L. 108-173, § 101(e)(1), substituted “part E” for “part D”.

Subsec. (j). Pub. L. 108-173, § 405(f)(1), inserted before period at end “, and for making grants to all States under paragraphs (1) and (2) of subsection (g) of this section, \$35,000,000 in each of fiscal years 2005 through 2008”.

1999—Subsec. (c)(2)(A). Pub. L. 106-113, § 1000(a)(6) [title IV, § 403(c)(1)], substituted “subparagraphs (B), (C), and (D)” for “subparagraph (B)”.

Subsec. (c)(2)(B)(i). Pub. L. 106-113, § 1000(a)(6) [title IV, § 403(b)], substituted “hospital” for “nonprofit or public hospital”.

Pub. L. 106-113, § 1000(a)(6) [title IV, § 401(b)(2)], inserted “or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title” after “section 1395ww(d)(2)(D) of this title”.

Pub. L. 106-113, § 1000(a)(6) [title III, § 321(a)], substituted “that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title), and that” for “and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that”.

Subsec. (c)(2)(B)(iii). Pub. L. 106-113, § 1000(a)(6) [title IV, § 403(a)(1)], substituted “for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;” for “for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;”.

Subsec. (c)(2)(C), (D). Pub. L. 106-113, § 1000(a)(6) [title IV, § 403(c)(2)], added subpars. (C) and (D).

Subsec. (g)(3). Pub. L. 106-113, § 1000(a)(6) [title IV, § 409], added par. (3).

1997—Pub. L. 105-33, § 4201(a), amended section catchline and text generally, substituting provisions relating to medicare rural hospital flexibility program for provisions relating to essential access community hospital program.

Subsec. (j). Pub. L. 105-33, § 4002(f)(1), substituted “part D” for “part C”.

1994—Subsec. (c)(1). Pub. L. 103-432, § 102(b)(2)(B)(i), substituted “paragraph (3) or subsection (k) of this section” for “paragraph (3)”.

Subsec. (e)(1). Pub. L. 103-432, § 102(b)(1)(A)(i), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: “is located in a rural area (as defined in section 1395ww(d)(2)(D) of this title);”.

Subsec. (e)(1)(A). Pub. L. 103-432, § 102(b)(1)(A)(ii), substituted “except in the case of a hospital located in an urban area, is located” for “is located” in introductory provisions, substituted “or (ii)” for “, (ii)”, and struck out “or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section,” after “section 1395ww(d)(5)(C) of this title,”.

Subsec. (e)(2) to (6). Pub. L. 103-432, § 102(b)(1)(A)(i), redesignated pars. (2) to (6) as (1) to (5), respectively.

Subsec. (f)(1)(F). Pub. L. 103-432, § 102(a)(1), amended subpar. (F) generally. Prior to amendment, subpar. (F) read as follows: “provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;”.

Subsec. (f)(1)(H). Pub. L. 103-432, § 102(f), inserted before period at end “, except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a ‘physician’ is a reference to a physician as defined in section 1395x(r)(1) of this title”.

Subsec. (f)(3). Pub. L. 103-432, § 102(c), substituted “because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1395tt of this title under which the facility’s inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.” for “because the facility has entered into an agreement with the Secretary under section 1395tt of this title under which the facility’s inpatient hospital facilities may be used for the furnishing of extended care services.”

Subsec. (f)(4). Pub. L. 103-432, § 102(a)(2), added par. (4).

Subsec. (i)(1)(A). Pub. L. 103-432, § 102(b)(2)(B)(ii), in cl. (i) inserted “(except as provided in subsection (k) of this section)” and in cl. (ii) inserted “or subsection (k) of this section”.

Subsec. (i)(1)(B). Pub. L. 103-432, § 102(b)(1)(A)(iii), substituted “paragraph (2)” for “paragraph (3)”.

Subsec. (i)(2)(A). Pub. L. 103-432, § 102(b)(2)(B)(ii), in cl. (i) inserted “(except as provided in subsection (k) of this section)” and in cl. (ii) inserted “or subsection (k) of this section”.

Subsec. (k). Pub. L. 103-432, § 102(b)(2)(A)(ii), added subsec. (k). Former subsec. (k) redesignated (l).

Subsec. (l). Pub. L. 103-432, § 102(h), substituted “1990 through 1997” for “1990, 1991, and 1992” in introductory provisions.

Pub. L. 103-432, § 102(b)(2)(A)(i), redesignated subsec. (k) as (l).

1990—Subsec. (d)(1). Pub. L. 101-508, § 4008(m)(2)(B)(i), struck out “demonstration” before “program”.

Subsec. (f)(1)(A). Pub. L. 101-508, § 4008(d)(3), inserted before semicolon at end “, or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas”.

Subsec. (f)(1)(B). Pub. L. 101-508, § 4008(d)(2), which directed the substitution of “is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),” for “is a hospital,” was executed by making the substitution for “is a hospital” to reflect the probable intent of Congress.

Subsec. (g)(1)(A)(ii). Pub. L. 101-508, § 4008(m)(2)(B)(ii), substituted “regional referral center” for “rural referral center”.

Subsec. (i)(2)(C). Pub. L. 101-508, § 4008(d)(1), inserted at end “In designating facilities as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) of this section with a rural health network located in a State receiving a grant under subsection (a)(1) of this section.”

Subsec. (j). Pub. L. 101-508, § 4008(m)(2)(B)(iii), inserted “and part C of this subchapter” after “this part”.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title III, § 3129(c), Mar. 23, 2010, 124 Stat. 427, provided that: “The amendments made by this section [amending this section] shall apply to grants made on or after January 1, 2010.”

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title IV, § 405(e)(3), Dec. 8, 2003, 117 Stat. 2267, provided that: “The amendments made by this subsection [amending this section] shall apply to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.”

Amendment by section 405(g)(1) of Pub. L. 108-173 applicable to cost reporting periods beginning on or after Oct. 1, 2004, see section 405(g)(3) of Pub. L. 108-173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 321(a)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Pub. L. 106-113, div. B, § 1000(a)(6) [title IV, § 401(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-369, provided that: “The amendments made by this section [amending this section and sections 1395f and 1395vw of this title] shall become effective on January 1, 2000.”

Pub. L. 106-113, div. B, § 1000(a)(6) [title IV, § 403(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-370, provided that: “The amendment made by paragraph (1) [amending this section] takes effect on the date of the enactment of this Act [Nov. 29, 1999].”

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(a) of Pub. L. 105-33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105-33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101-508, title IV, § 4008(d)(4), Nov. 5, 1990, 104 Stat. 1388-45, provided that: “The amendments made by paragraphs (1), (2), and (3) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].”

DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES

Pub. L. 110-275, title I, § 123, July 15, 2008, 122 Stat. 2514, as amended by Pub. L. 111-148, title III, § 3126, Mar. 23, 2010, 124 Stat. 425, provided that:

“(a) IN GENERAL.—The Secretary shall establish a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating the delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries.

“(b) PURPOSE.—The purpose of the demonstration project under this section is to—

“(1) explore ways to increase access to, and improve the adequacy of, payments for acute care, extended

care, and other essential health care services provided under the Medicare and Medicaid programs in eligible counties; and

“(2) evaluate regulatory challenges facing such providers and the communities they serve.

“(c) REQUIREMENTS.—The following requirements shall apply under the demonstration project:

“(1) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall (when determined appropriate by the Secretary), instead of the payment rates otherwise applicable under the Medicare program, be reimbursed at a rate that covers at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries.

“(2) Methods to coordinate the survey and certification process under the Medicare program and the Medicaid program across all health service categories included in the demonstration project shall be tested with the goal of assuring quality and safety while reducing administrative burdens, as appropriate, related to completing such survey and certification process.

“(3) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) and the Secretary shall work with the State to explore ways to revise reimbursement policies under the Medicaid program to improve access to the range of health care services available in such eligible counties.

“(4) The Secretary shall identify regulatory requirements that may be revised appropriately to improve access to care in eligible counties.

“(5) Other essential health care services necessary to ensure access to the range of health care services in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall be identified. Ways to ensure adequate funding for such services shall also be explored.

“(d) APPLICATION PROCESS.—

“(1) ELIGIBILITY.—

“(A) IN GENERAL.—Eligibility to participate in the demonstration project under this section shall be limited to eligible entities.

“(B) ELIGIBLE ENTITY DEFINED.—In this section, the term ‘eligible entity’ means an entity that—

“(i) is a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act (42 U.S.C. 1395i-4(g)); and

“(ii) is located in a State in which at least 65 percent of the counties in the State are counties that have 6 or less residents per square mile.

“(2) APPLICATION.—

“(A) IN GENERAL.—An eligible entity seeking to participate in the demonstration project under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(B) LIMITATION.—The Secretary shall select eligible entities located in not more than 4 States to participate in the demonstration project under this section.

“(3) SELECTION OF ELIGIBLE COUNTIES.—An eligible entity selected by the Secretary to participate in the demonstration project under this section shall select eligible counties in the State in which the entity is located in which to conduct the demonstration project.

“(4) ELIGIBLE COUNTY DEFINED.—In this section, the term ‘eligible county’ means a county that meets the following requirements:

“(A) The county has 6 or less residents per square mile.

“(B) As of the date of the enactment of this Act [July 15, 2008], a facility designated as a critical access hospital which meets the following requirements was located in the county:

“(i) As of the date of the enactment of this Act, the critical access hospital furnished 1 or more of the following:

“(I) Home health services.

“(II) Hospice care.

“(ii) As of the date of the enactment of this Act, the critical access hospital has an average daily inpatient census of 5 or less.

“(C) As of the date of the enactment of this Act, skilled nursing facility services were available in the county in—

“(i) a critical access hospital using swing beds;

or

“(ii) a local nursing home.

“(e) ADMINISTRATION.—

“(1) IN GENERAL.—The demonstration project under this section shall be administered jointly by the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration and the Administrator of the Centers for Medicare & Medicaid Services, in accordance with paragraphs (2) and (3).

“(2) HRSA DUTIES.—In administering the demonstration project under this section, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration shall—

“(A) award grants to the eligible entities selected to participate in the demonstration project; and

“(B) work with such entities to provide technical assistance related to the requirements under the project.

“(3) CMS DUTIES.—In administering the demonstration project under this section, the Administrator of the Centers for Medicare & Medicaid Services shall determine which provisions of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) the Secretary should waive under the waiver authority under subsection (i) that are relevant to the development of alternative reimbursement methodologies, which may include, as appropriate, covering at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries and coordinating the survey and certification process under the Medicare and Medicaid programs, as appropriate, across all service categories included in the demonstration project.

“(f) DURATION.—

“(1) IN GENERAL.—The demonstration project under this section shall be conducted for a 3-year period beginning on October 1, 2009.

“(2) BEGINNING DATE OF DEMONSTRATION PROJECT.—The demonstration project under this section shall be considered to have begun in a State on the date on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.

“(g) FUNDING.—

“(1) CMS.—

“(A) IN GENERAL.—The Secretary shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of such sums as are necessary for the costs to the Centers for Medicare & Medicaid Services of carrying out its duties under the demonstration project under this section.

“(B) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration project under this section was not implemented.

“(2) HRSA.—There are authorized to be appropriated to the Office of Rural Health Policy of the Health Resources and Services Administration \$800,000 for each of fiscal years 2010, 2011, and 2012 for the purpose of carrying out the duties of such Office

under the demonstration project under this section, to remain available for the duration of the demonstration project.

“(h) REPORT.—

“(1) INTERIM REPORT.—Not later than the date that is 2 years after the date on which the demonstration project under this section is implemented, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on the status of the demonstration project that includes initial recommendations on ways to improve access to, and the availability of, health care services in eligible counties based on the findings of the demonstration project.

“(2) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

“(i) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary and appropriate for the purpose of carrying out the demonstration project under this section.

“(j) DEFINITIONS.—In this section:

“(1) EXTENDED CARE SERVICES.—The term ‘extended care services’ means the following:

“(A) Home health services.

“(B) Covered skilled nursing facility services.

“(C) Hospice care.

“(2) COVERED SKILLED NURSING FACILITY SERVICES.—The term ‘covered skilled nursing facility services’ has the meaning given such term in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)).

“(3) CRITICAL ACCESS HOSPITAL.—The term ‘critical access hospital’ means a facility designated as a critical access hospital under section 1820(c) of such Act (42 U.S.C. 1395l-4(c)).

“(4) HOME HEALTH SERVICES.—The term ‘home health services’ has the meaning given such term in section 1861(m) of such Act (42 U.S.C. 1395x(m)).

“(5) HOSPICE CARE.—The term ‘hospice care’ has the meaning given such term in section 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

“(6) MEDICAID PROGRAM.—The term ‘Medicaid program’ means the program under title XIX of such Act (42 U.S.C. 1396 et seq.).

“(7) MEDICARE PROGRAM.—The term ‘Medicare program’ means the program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

“(8) OTHER ESSENTIAL HEALTH CARE SERVICES.—The term ‘other essential health care services’ means the following:

“(A) Ambulance services (as described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7))).

“(B) Physicians’ services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)[I])).

“(C) Public health services (as defined by the Secretary).

“(D) Other health care services determined appropriate by the Secretary.

“(9) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.” [Pub. L. 111-148, title III, §3126(b)(1), Mar. 23, 2010, 124 Stat. 426, which directed amendment of section 123 of Pub. L. 111-275, set out above, by striking out subsec. (d)(4)(B)(i)(3)(III), was executed by striking out subsec. (d)(4)(B)(i)(III) to reflect the probable intent of Congress.]

GAO STUDY ON CERTAIN ELIGIBILITY REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS

Pub. L. 106-554, §1(a)(6) [title II, §206], Dec. 21, 2000, 114 Stat. 2763, 2763A-483, provided that:

“(a) **STUDY.**—The Comptroller General of the United States shall conduct a study on the eligibility requirements for critical access hospitals under section 1820(c) of the Social Security Act (42 U.S.C. 1395i-4(c)) with respect to limitations on average length of stay and number of beds in such a hospital, including an analysis of—

“(1) the feasibility of having a distinct part unit as part of a critical access hospital for purposes of the medicare program under title XVIII of such Act [this subchapter]; and

“(2) the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limitations on average annual length of stay and number of beds.

“(b) **REPORT.**—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) together with recommendations regarding—

“(1) whether distinct part units should be permitted as part of a critical access hospital under the medicare program;

“(2) if so permitted, the payment methodologies that should apply with respect to services provided by such units;

“(3) whether, and to what extent, such units should be included in or excluded from the bed limits applicable to critical access hospitals under the medicare program; and

“(4) any adjustments to such eligibility requirements to account for seasonal variations in patient admissions.”

TRANSITION FOR MAF

Pub. L. 105-33, title IV, § 4201(c)(6), Aug. 5, 1997, 111 Stat. 374, provided that:

“(A) **IN GENERAL.**—The Secretary of Health and Human Services shall provide for an appropriate transition for a facility that, as of the date of the enactment of this Act [Aug. 5, 1997], operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101-508] (42 U.S.C. 1395b-1 note) from such demonstration to the program established under subsection (a) [amending this section]. At the conclusion of the transition period described in subparagraph (B), the Secretary shall end such demonstration.

“(B) **TRANSITION PERIOD DESCRIBED.**—

“(i) **INITIAL PERIOD.**—Subject to clause (ii), the transition period described in this subparagraph is the period beginning on the date of the enactment of this Act and ending on October 1, 1998.

“(ii) **EXTENSION.**—If the Secretary determines that the transition is not complete as of October 1, 1998, the Secretary shall provide for an appropriate extension of the transition period.”

GAO REPORTS

Pub. L. 103-432, title I, § 102(a)(4), Oct. 31, 1994, 108 Stat. 4402, directed Comptroller General to submit to Congress, not later than 2 years after Oct. 31, 1994, reports on application of requirements under subsec. (f) of this section that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain average length of inpatient stay during a year that does not exceed 72 hours, and extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited ability of such hospitals to provide needed services.

§ 1395i-5. Conditions for coverage of religious nonmedical health care institutional services

(a) In general

Subject to subsections (c) and (d) of this section, payment under this part may be made for

inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution and for home health services furnished an individual by a religious nonmedical health care institution only if—

(1) the individual has an election in effect for such benefits under subsection (b) of this section; and

(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services, extended care services, or home health services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility, or receiving services from a home health agency, that was not such an institution.

(b) Election

(1) In general

An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

(2) Form

The election form under this subsection shall include the following:

(A) A written statement, signed by the individual (or such individual's legal representative), that—

(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a) of this section.

(3) Revocation

An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revocation and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this subchapter.

(4) Limitation on subsequent elections

Once an individual's election under this subsection has been made and revoked twice—

(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

(5) Excepted medical treatment

For purposes of this subsection:

(A) Excepted medical treatment

The term “excepted medical treatment” means medical care or treatment (including medical and other health services)—

- (i) received involuntarily, or
- (ii) required under Federal or State law or law of a political subdivision of a State.

(B) Nonexcepted medical treatment

The term “nonexcepted medical treatment” means medical care or treatment (including medical and other health services) other than excepted medical treatment.

(c) Monitoring and safeguard against excessive expenditures

(1) Estimate of expenditures

Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) of this section for that fiscal year.

(2) Adjustment in payments

(A) Proportional adjustment

If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) of this section for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

(B) Alternative adjustments

The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

(C) Trigger level

For purposes of this subsection—

(i) In general

Subject to adjustment under paragraph (3)(B), the “trigger level” for a year is the unadjusted trigger level described in clause (ii).

(ii) Unadjusted trigger level

The “unadjusted trigger level” for—

- (I) fiscal year 1998, is \$20,000,000, or
- (II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

(D) Prohibition of administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of the esti-

mation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

(E) Effect on billing

Notwithstanding any other provision of this subchapter, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

(3) Monitoring expenditure level

(A) In general

The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

(B) Adjustment in trigger level

(i) In general

If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

(ii) Limitation on carryforward

In no case may the increase effected under clause (i) for a fiscal year exceed \$50,000,000.

(d) Sunset

If the Secretary determines that the level of expenditures described in subsection (c)(1) of this section for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2) of this section), benefits shall be paid under this part for services described in subsection (a) of this section and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) of this section as of such January 1 and only during the duration of such election.

(e) Annual report

At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) of this section under this part and under State plans under subchapter XIX of this chapter. Such report shall include—

- (1) level of expenditures described in subsection (c)(1) of this section for the previous fiscal year and estimated for the fiscal year involved;
- (2) trends in such level; and
- (3) facts and circumstances of any significant change in such level from the level in previous fiscal years.

(Aug. 14, 1935, ch. 531, title XVIII, § 1821, as added Pub. L. 105-33, title IV, § 4454(a)(2), Aug. 5, 1997,

111 Stat. 428; amended Pub. L. 108-173, title VII, § 706(a), Dec. 8, 2003, 117 Stat. 2339.)

AMENDMENTS

2003—Subsec. (a). Pub. L. 108-173, § 706(a)(1), inserted “and for home health services furnished an individual by a religious nonmedical health care institution” after “religious nonmedical health care institution” in introductory provisions.

Subsec. (a)(2). Pub. L. 108-173, § 706(a)(2), substituted “, extended care services, or home health services” for “or extended care services” and inserted “, or receiving services from a home health agency,” after “skilled nursing facility”.

EFFECTIVE DATE

Pub. L. 105-33, title IV, § 4454(d), Aug. 5, 1997, 111 Stat. 431, provided that: “The amendments made by this section [enacting this section and amending sections 1320a-1, 1320c-11, 1395x, 1396a, and 1396g of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act [42 U.S.C. 1395i-5(b)].”

PART B—SUPPLEMENTARY MEDICAL INSURANCE
BENEFITS FOR AGED AND DISABLED**§ 1395j. Establishment of supplementary medical insurance program for aged and disabled**

There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

(Aug. 14, 1935, ch. 531, title XVIII, § 1831, as added Pub. L. 89-97, title I, § 102(a), July 30, 1965, 79 Stat. 301; amended Pub. L. 92-603, title II, § 201(a)(3), Oct. 30, 1972, 86 Stat. 1371.)

AMENDMENTS

1972—Pub. L. 92-603 substituted “aged and disabled individuals” for “individuals 65 years of age or over”.

STUDY REGARDING COVERAGE UNDER PART B OF MEDICAL CARE FOR NONREIMBURSABLE SERVICES PROVIDED BY OPTOMETRISTS FOR PROSTHETIC LENSES FOR PATIENTS WITH APHAKIA

Pub. L. 94-182, title I, § 109, Dec. 31, 1975, 89 Stat. 1053, provided that the Secretary of Health, Education, and Welfare conduct a study on the appropriateness of reimbursement under the insurance program established by this part for services performed by optometrists with respect to the provision of prosthetic lenses for patients with aphakia and submit such study to Congress not later than 4 months after Dec. 31, 1975.

STUDY TO DETERMINE FEASIBILITY OF INCLUSION OF CERTAIN ADDITIONAL SERVICES UNDER PART B

Pub. L. 90-248, title I, § 141, Jan. 2, 1968, 81 Stat. 855, directed Secretary to conduct a study relating to inclusion under the supplementary medical insurance program under this part of services of additional types of licensed practitioners performing health services in

independent practice and submit such study to Congress prior to Jan. 1, 1969.

§ 1395k. Scope of benefits; definitions**(a) Scope of benefits**

The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2) and subparagraphs (E) and (F) of section 1395u(b)(6) of this title; and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1395x(b) of this title (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met,

(ii) services for which payment may be made pursuant to section 1395n(b)(2) of this title,

(iii) services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;¹

(iv) services of a nurse practitioner or clinical nurse specialist but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services; and²

(C) outpatient physical therapy services (other than services to which the second sentence of section 1395x(p) of this title applies), outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1395x(g) of this title), and outpatient speech-language pathology services (other than services to which the second sentence of section 1395x(p) of this title applies through the application of section 1395x(l)(2) of this title);

(D)(i) rural health clinic services and (ii) Federally qualified health center services;

(E) comprehensive outpatient rehabilitation facility services;

¹ So in original. The semicolon probably should be a comma.

² So in original. The word “and” probably should not appear.