“(iv) no indebtedness to the United States, as a result of the disaffirmation by an individual, pursuant to this subparagraph, of an election made by such individual under such section 306 shall be considered to arise from the payment of pension pursuant to such an election.

(5) The Administrator shall promptly advise the Secretary of Health, Education, and Welfare [now Health and Human Services], and provide identification of the individuals involved and other pertinent information with respect to an individual, shall promptly notify the appropriate agencies administering State plans applicable to the reestablishment of elections previously made, and (iii) individuals who, after having disaffirmed an election under subparagraph (B), subsequently again make an election under section 306 of the Veterans’ and Survivors’ Pension Improvement Act of 1978 [Pub. L. 95–588, set out as a note under section 1521 of Title 38].

§ 1320b–4. Nonprofit hospital or critical access hospital philanthropy

For purposes of determining, under subchapters XVIII and XIX of this chapter, the reasonable costs of services provided by nonprofit hospitals or critical access hospitals, the following items shall not be deducted from the operating costs of such hospitals or critical access hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity, and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged).

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset was made by a governmental entity, and income therefrom, which the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.


§ 1320b–5. Authority to waive requirements during national emergencies

(a) Purpose

The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1))—

(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under subchapters XVIII, XIX, and XXI; and

(2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) Secretarial authority

To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX, or XXI, or any amendments.
regulation thereunder (and the requirements of this subchapter other than this section, and regulations thereunder, insofar as they relate to such subchapters), pertaining to—

(1) (A) conditions of participation or other certification requirements for an individual health care provider or types of providers,

(B) program participation and similar requirements for an individual health care provider or types of providers, and

(C) pre-approval requirements;

(2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

(3) actions under section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for—

(A) a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period; or

(B) the direction or relocation of an individual to receive medical screening in an alternative location—

(i) pursuant to an appropriate State emergency preparedness plan; or

(ii) in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;

(4) sanctions under section 1395m(g) of this title (relating to limitations on physician referral);

(5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived;

(6) limitations on payments under section 1395w-21(i) of this title for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan;

(7) sanctions and penalties that arise from noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note))—

(A) section 164.510 of title 45, Code of Federal Regulations, relating to—

(i) requirements to obtain a patient’s agreement to speak with family members or friends; and

(ii) the requirement to honor a request to opt out of the facility directory;

(B) section 164.520 of such title, relating to the requirement to distribute a notice; or

(C) section 164.522 of such title, relating to—

(i) the patient’s right to request privacy restrictions; and

(ii) the patient’s right to request confidential communications; and

(8) in the case of a telehealth service (as defined in paragraph (4)(F) of section 1395m(m) of this title) furnished in any emergency area (or portion of such an area) during any portion of any emergency period, the requirements of section 1395m(m) of this title.

Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of subchapter XVIII. A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider. If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies.

(c) Authority for retroactive waiver

A waiver or modification of requirements pursuant to this section may, at the Secretary’s discretion, be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary.

(d) Certification to Congress

The Secretary shall provide a certification and advance written notice to the Congress at least two days before exercising the authority under this section with respect to an emergency area. Such a certification and notice shall include—

(1) a description of—

(A) the specific provisions that will be waived or modified;

(B) the health care providers to whom the waiver or modification will apply;

(C) the geographic area in which the waiver or modification will apply; and

(D) the period of time for which the waiver or modification will be in effect; and

(2) a certification that the waiver or modification is necessary to carry out the purpose specified in subsection (a).
(e) Duration of waiver

(1) In general

A waiver or modification of requirements pursuant to this section terminates upon—

(A) the termination of the applicable declaration of emergency or disaster described in subsection (g)(1)(A);

(B) the termination of the applicable declaration of public health emergency described in subsection (g)(1)(B); or

(C) subject to paragraph (2), the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification under paragraph (2)).

(2) Extension of 60-day periods

The Secretary may, by notice, provide for an extension of a 60-day period described in paragraph (1)(C) (or an additional period provided under this paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days each), but any such extension shall not affect or prevent the termination of a waiver or modification described in subparagraph (A) or (B) of paragraph (1).

(f) Report to Congress

Within one year after the end of the emergency period in an emergency area in which the Secretary exercised the authority provided under this section, the Secretary shall report to the Congress regarding the approaches used to accomplish the purposes described in subsection (a), including an evaluation of such approaches and recommendations for improved approaches should the need for such emergency authority arise in the future.

(g) Definitions

For purposes of this section:

(1) Emergency area; emergency period

(A) In general

Subject to subparagraph (B), an “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exists—

(i) an emergency or disaster declared by the President pursuant to the National Emergencies Act [50 U.S.C. 1601 et seq.] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.]; and

(ii) a public health emergency declared by the Secretary pursuant to section 247d of this title.

(B) Exception

For purposes of subsection (b)(6), an “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exists—

(i) the public health emergency declared by the Secretary pursuant to section 247d of this title on January 31, 2020, entitled “Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus”;

(ii) any renewal of such declaration pursuant to such section 247d of this title.

(2) Health care provider

The term “health care provider” means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.


REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (b)(7), is section 264(c) of Pub. L. 101–191, which is set out as a note under section 1320d–2 of this title.


Prior Provisions


Amendments

2020—Subsec. (b)(8), Pub. L. 116–116, §3703(1), substituted “; the requirements of section 1395m(m) of this title;” for “; the requirements of a qualified provider (as defined in subsection (g)(3));”

“(A) the requirements of paragraph (4)(C) of such section, except that a facility fee under paragraph (2)(B)(i) of such section may only be paid to an originating site that is a site described in any of subsections (I) through (IX) of paragraph (4)(C)(ii) of such section; and

“(B) the restriction on use of a telephone described in the second sentence of section 410.78a(3) of title 42, Code of Federal Regulations (or a successor regulation), but only if such telephone has audio and video capabilities that are used for two-way, real-time interactive communication.”


Subsec. (g)(1), Pub. L. 116–123, §102(b), amended par. (1) generally. Prior to amendment, text read as follows: “An ‘emergency area’ is a geographical area in which, and an ‘emergency period’ is the period during which, there exists—

“(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act...
or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

(B) a public health emergency declared by the Secretary pursuant to section 320d of this title.

Subsec. (g)(3). Pub. L. 116–136, §3703(2), struck out par. (3) which defined the term “qualified provider”.


Subsec. (g)(3)(A). Pub. L. 116–127 amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: “furnished to such individual an item or service for which payment was made under subgroup XVIII during the 3-year period ending on the date such tele-health service was furnished or;”.

2006—Subsec. (b). Pub. L. 109–417, §302(b)(1)(B), (C), in concluding provisions, substituted “and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to” for “‘and shall be limited to’” and inserted at end “‘If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies.’”

Subsec. (g)(3)(B). Pub. L. 109–417, §302(b)(1)(A), added subpar. (B) and struck out former subpar. (B) which read as follows: “the direction or relocation of an individual to receive medical screening in an alternate location pursuant to an appropriate State emergency preparedness plan.”

2004—Subsec. (b). Pub. L. 108–276, §8(b), inserted at end of concluding provisions: “A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider.”

Subsec. (b)(7). Pub. L. 108–276, §8(1), added par. (3) and struck out former par. (3) which read as follows: “sanctions under section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of this section of such transfer arises out of the circumstances of the emergency.”


CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–417, title III, §302(b)(2), Dec. 19, 2006, 120 Stat. 2856, provided that: “The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 19, 2006] and shall apply to public health emergencies declared pursuant to section 319 of the Public Health Service Act (42 U.S.C. 247d) on or after such date.”

EFFECTIVE DATE

Pub. L. 107–188, title I, §143(b), June 12, 2002, 116 Stat. 629, provided that: “The amendment made by subsection (a) [amending this section] shall be effective on and after September 11, 2001.”

COVERAGE OF TESTING FOR COVID–19


“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) (as defined in section 1251(e)) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(e)) shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(c) of the Social Security Act (42 U.S.C. 1320c–5(g)) beginning on or after the date of the enactment of this Act [Mar. 18, 2020]:

“(1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such test;

“(A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bb–3);

“(B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

“(C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or

“(D) other test that the Secretary determines appropriate in guidance.

“(2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and tele-health visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

“(b) ENFORCEMENT.—The provisions of subsection (a) shall be applied by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury to group health plans and health insurance issuers offering group or individual health insurance coverage as if included in the provisions of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), part 7 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1102, et seq.), and subchapter B of chapter 100 of the Internal Revenue Code of 1986 (26 U.S.C. 9811 et seq.), as applicable.

“(c) IMPLEMENTATION.—The Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury may implement the provisions of this section through sub-regulatory guidance, program instruction or otherwise.

“(d) TERMS.—The terms ‘group health plan’; ‘health insurance issuer’; ‘group health insurance coverage’, and ‘individual health insurance coverage’ have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 772 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101b), and section 8332 of the Internal Revenue Code of 1986 (26 U.S.C. 9832), as applicable.”

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–123, div. B, §102(a)(3), Mar. 6, 2020, 134 Stat. 156, provided that: “The Secretary of Health and Human Services may implement the provisions of this subsection by program instruction or otherwise.”
§ 1320b–6. Exclusion of representatives and health care providers convicted of violations from participation in social security programs

(a) In general

The Commissioner of Social Security shall exclude from participation in the social security programs any representative or health care provider—

(1) who is convicted of a violation of section 408 or 1383a of this title;
(2) who is convicted of any violation under title 18 relating to an initial application for or continuing entitlement to, or amount of, benefits under subchapter II of this chapter, or an initial application for or continuing eligibility for, or amount of, benefits under subchapter XVI of this chapter; or
(3) who the Commissioner determines has committed an offense described in section 1320a–8(a)(1) of this title.

(b) Notice, effective date, and period of exclusion

(1) An exclusion under this section shall be effective at such time, for such period, and upon such reasonable notice to the public and to the individual excluded as may be specified in regulations consistent with paragraph (2).
(2) Such an exclusion shall be effective with respect to services furnished to any individual on or after the effective date of the exclusion. Nothing in this section may be construed to preclude, in determining disability under subchapter II or subchapter XVI, consideration of the activities of the State agency in the course of its employment.

(c) Notice to State agencies

The Commissioner shall promptly notify each State agency employed for the purpose of making disability determinations under section 421 or 1383b(a) of the fact and circumstances of each determination made under this subsection.

(d) Notice to State licensing agencies

The Commissioner shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual excluded from participation under this section of the fact and circumstances of the exclusion;
(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy; and
(3) request that the State or local agency or authority keep the Commissioner and the Inspector General of the Social Security Administration fully and currently informed with respect to any actions taken in response to the request.

(e) Notice, hearing, and judicial review

(1) Any individual who is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Commissioner to the same extent as is provided in section 405(b) of this title, and to judicial review of the Commissioner’s final decision after such hearing as is provided in section 405(g) of this title.
(2) The provisions of section 405(h) of this title shall apply with respect to this section to the same extent as it is applicable with respect to subchapter II.

(f) Application for termination of exclusion

(1) An individual excluded from participation under this section may apply to the Commissioner in regulations and at the end of the minimum period of exclusion provided under subsection (b)(3) and at such other times as the Commissioner may provide, for termination of the exclusion effected under this section.
(2) The Commissioner may terminate the exclusion if the Commissioner determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion which was unknown to the Commissioner at the time of the exclusion, that—
(A) there is no basis under subsection (a) for a continuation of the exclusion; and
(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.
(3) The Commissioner shall promptly notify each State agency employed for the purpose of making disability determinations under section 421 or 1383b(a) of the fact and circumstances of each termination of exclusion made under this subsection.

(g) Availability of records of excluded representatives and health care providers

Nothing in this section shall be construed to have the effect of limiting access by any applicant or beneficiary under subchapter II or XVI,